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1999 STATE OF THE CITY PUBLIC HEALTH ADDRESS

***Presented to the
San Francisco Board of Supervisors
May 10, 1999***

***The mission of the San Francisco Department of
Public Health is to promote and protect the health of
all San Franciscans.***

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***Mitchell H. Katz, M.D.
Director of Health
San Francisco Department of Public Health***

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Director of Health

1999 STATE OF THE CITY PUBLIC HEALTH ADDRESS

President Ammiano and Members of the San Francisco Board of Supervisors:

Thank you for the opportunity to speak to you today on the state of public health in our City. It is an honor to appear before this Board which, with the Mayor, has provided such consistent and effective leadership to preserve and improve the health of the City.

This has been a very challenging year for public health in San Francisco as we have been hard hit by revenue shortfalls. The causes of these shortfalls, which are national in scope, threaten public and non-profit hospitals across the state and the country. The federal Balanced Budget Act has resulted in significantly less Medicaid and Medicare reimbursement for acute care hospitalization. The result is that San Francisco General Hospital, and many other public and university hospitals that care for predominantly poor populations are facing multi-million dollar operating deficits.

In the State of California, despite a prosperous economy, the proportion of employed persons with health insurance has actually decreased. Employers increasingly offer part-time or full-time work without benefits as a way of making their businesses more profitable. The result is more uninsured persons who must rely on the public health system for their health care.

Finally, our hospital, as well as other non-profit hospitals in San Francisco, is full. Although no one can say for certain what is the cause of higher census at our acute care hospitals, plausible explanations include: the aging of the population, a larger number of persons living with chronic diseases, and the inadequacies of medical care under managed care capitation. To give you some idea of the scope, San Francisco General Hospital had a peak census of 40 patients above our budgeted level in February, 1999.

Pilot Project Task Force was formed to develop a long-term care services system to meet the needs of elderly and disabled persons.

Although AIDS cases have been declining since 1992, and deaths have been declining since 1995, AIDS continued to be the leading cause of preventable death in San Francisco, as measured by the expected number of years lost in a person's life who dies from the disease. Due to improved treatment, the number of persons living with AIDS is increasing. Declines in the number of AIDS cases have not been as great among women, youth, and persons of color, indicating unmet needs in the area of HIV prevention. The Board can be proud that because of its bold and early support of needle exchange, we have averted potentially thousands of HIV infections among injection drug users.

Sexually transmitted disease rates in San Francisco have consistently declined since the late 1970s, but they are still well above those of California and the nation as a whole. For the fifth consecutive year, the number of new tuberculosis (TB) cases in San Francisco has declined. Despite this promising trend, the TB case rate in San Francisco is four times the national rate and double the California rate. This is primarily due to the fact that San Francisco has a larger immigrant and HIV/AIDS population, both of whom have greater incidences of TB.

Hepatitis C has emerged this year as a problem demanding our increased attention. The disease is associated with sharing of needles by injection drug users. In some populations of active injection drug users, the prevalence of hepatitis C, is as high as 95%. We are actively working with the Centers for Disease Control to obtain federal funds to adequately respond to this emerging epidemic.

Substance abuse plays a major role in the cause of disease in San Francisco. Alcohol, tobacco, and other drugs contribute to approximately one fifth of San Francisco's mortality. In addition, drug overdose is San Francisco's fifth leading cause of premature death. I am deeply grateful to this Board, which has embraced the goals of treatment on demand. With your help, and the hard work of the community-based Treatment on Demand Planning Council, we have greatly expanded our treatment capacity to a total of 13,406 treatment slots.

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The high prevalence of mental illness in our City continues to be a major concern. Mental health is closely linked to substance abuse and homelessness. As you know, our goal has been to ensure a single standard of care and equal access to mental health services regardless of a person's ability to pay for services. With the support of this Board, we have taken a large step in that direction. I am pleased that our Department, with the support of community mental health providers, has developed the San Francisco Mental Health Managed Care Plan, and that it has functioned well.

I am extremely proud of the many achievements of the Department during the past year. Despite fiscal challenges, we have expanded services, undertaken major Citywide planning efforts, and strengthened our emphasis on health promotion and prevention. Service expansions have occurred in the areas of HIV/AIDS, mental health, children's health, substance abuse treatment, housing, environmental health, and family planning.

Before closing I would like to acknowledge a special debt of gratitude to the San Francisco Health Commission whose guidance and leadership is indispensable, and to the Department's dedicated staff.

Thank you for the opportunity to speak to you today regarding the public health of our City. The attached written report provides additional information on issues I have covered and many other issues that I did not have time to discuss in my oral comments. I look forward to working closely with the Board over the next year to protect and promote the health of all San Franciscans.

SELECTED PUBLIC HEALTH DATA, ISSUES AND CITY RESPONSES

Public Health Issues

- ❑ Many of San Francisco's public health issues are the same as those found in other densely populated urban areas; some are specific to the composition of the City's population:
 - a high proportion of deaths that could be reduced by prevention
 - high prevalence of mental health problems
 - aging population with increasing long-term care needs
 - increased tobacco use among youth
 - high risk behaviors among children and youth
 - high prevalence of HIV/AIDS
 - homelessness
 - high substance abuse/addiction
 - environmental health concerns

Public Health Issues (cont.)

- high and growing number of uninsured
- persistently high incidences of some communicable diseases
- disparities in the health status of different racial and ethnic communities
- variable access to culturally-sensitive health services for different cultural groups
- high levels of violence, homicide and suicide.

Healthy People 2000 Objectives

- ❑ Developed by the Disease Prevention and Health Promotion division of the US Department of Health and Human Services.
- ❑ Focuses on three broad goals
 - increasing the years of healthy life
 - reducing health disparities among diverse populations
 - achieving access to clinical preventive services.
- ❑ Have become the standard to measure the health of a community.
- ❑ Being updated to set goals for 2010.

Leading Causes of Death*

- 1 Heart Disease
- 2 All Cancers
- 3 AIDS
- 4 Stroke
- 5 Pneumonia/ Influenza
- 6 Injuries/ Accidents
- 7 Chronic Obstructive Pulmonary Disease
- 8 Diabetes
- 9 Suicide
- 10 Liver Disease/ Cirrhosis

* in rank order; 1990 -1995, San Francisco

Leading Causes of Death By Years of Life Lost - Men*

	<u>Deaths</u>	<u>Average Years of Life Lost</u>
1 HIV/ AIDS	6650	44
2 Heart Disease	5548	16
3 Lung Cancer	1439	19
4 Drug Overdose	588	45
5 Suicide	645	40
6 Homicide	456	52
7 Stroke	1345	15
8 Liver Cirrhosis	551	33
9 Pneumonia	1109	15
10 Motor Vehicle Accidents	296	44

* in rank order; deaths multiplied by average years of life lost; 1990 -1995, San Francisco

Leading Causes of Death By Years of Life Lost - Women*

	<u>Deaths</u>	<u>Average Years of Life Lost</u>
1 Heart Disease	5462	10
2 Stroke	2029	11
3 Lung Cancer	1016	17
4 Breast Cancer	722	21
5 Pneumonia	1194	9
6 HIV AIDS	182	45
7 Colorectal Cancer	538	15
8 Pulmonary Disease	622	13
9 Suicide	200	34
10 Drug Overdose	147	43

*in rank order; deaths multiplied by average years
of life lost; 1990 -1995, San Francisco

Racial/ Ethnic Health Status Disparities

- ❑ For the period 1987 -1995, African-American mortality rates for all causes of death were the highest of any group for both sexes in San Francisco.
- ❑ African-American males had the lowest life expectancy.
- ❑ Mission and Bayview - primarily Latino and African-American communities - had the highest rate of hospitalizations for assault in the City.
- ❑ Black infant mortality is the highest of any ethnic group and exceeds the Healthy People 2000 objective.
- ❑ Over half of all AIDS cases are in white gay/bisexual men.
- ❑ Three quarters of all new tuberculosis cases are in immigrants from Asia.
- ❑ Latinos have the highest rate of no health insurance (38% of the Latino population).

Racial/ Ethnic Health Status Disparities Response

- ❑ The Department has formed a coalition of health, environmental and social services - African American Health Initiatives - to assess the problems in San Francisco neighborhoods and recommend local solutions.
- ❑ The Department's Black Infant Health Improvement Project is one of several activities addressing black infant mortality.
- ❑ The Department is playing a key role on health issues with the Mission Community Planning Council.
- ❑ The Bayview/ Hunters Point Health and Environmental Resource Center is a resource on community health issues and health information.

Communicable Diseases

- ❑ Gonorrhea and syphilis rates in San Francisco are higher than the Healthy People 2000 objectives.
- ❑ Gonorrhea rates in the City are the highest in California and among the highest in the US.
- ❑ Tuberculosis cases have dropped 14.5% since 1997 and 42% since the resurgence of the disease in 1993.
- ❑ Despite the decline, TB rates are well above the Healthy People 2000 objective of 3.5 cases per 100,000 population.
- ❑ Estimates are that 18,000 San Franciscans are infected with Hepatitis C.

Communicable Diseases Response

- ❑ The Department has expanded STD control efforts aimed at those incarcerated in County jails and those at risk for early syphilis.
- ❑ The Department has a national-model Tuberculosis Control program that has contributed to the 5 year decline of the disease.
- ❑ TB monitoring and control in homeless shelters has been a Departmental priority.
- ❑ San Francisco has recently been selected by the Centers for Disease Control to be one of six Hepatitis Sentinel Counties in the nation.
- ❑ The Department participated with the CDC in developing new Hepatitis guidelines in 1998.
- ❑ Hepatitis prevention is being linked with HIV prevention efforts in the City.

Environmental Health

- ❑ Different communities in the City have environmental health concerns based on the past and current industries located in neighborhoods.
- ❑ Eleven underground storage tanks within the City are not in compliance with federal and state environmental regulations.
- ❑ The City has two problematic rat populations - one in the sewers and one in homes and built-up vegetation areas.
- ❑ Several significant illegal disposal sites have been identified in the City in recent years.
- ❑ Illegal dumping of hazardous waste in sections of the City continues to be a concern.

Environmental Health Response

- ❑ Bayview/ Hunters Point Health and Environmental Resource Center established by the Department to address neighborhood issues.
- ❑ Department with the City Attorney pursuing legal action against non-complying underground storage tanks.
- ❑ Successful rodent control programs implemented with the Public Utilities Commission, the San Francisco Urban League of Gardeners and Youth Community Developers.
- ❑ Grant funds and judgements obtained to clean up illegal dump sites.

HIV/AIDS

- ❑ Between 1990 and 1997, AIDS case declined 162.2% in all transmission categories but only 55.5% among African-Americans.
- ❑ In the same period, the number of cases among injection drug users declined only 3.5%.
- ❑ Cases in males declined 174.6% but did not decline in females over the 5 year period.
- ❑ Heterosexual AIDS case declined only 17.4% during the 5 year period.
- ❑ HIV prevention strategies must respond to issues such as substance abuse, sexual experimentation, mental health, self-esteem and poverty.

HIV/AIDS Response

- ❑ Expanded treatment advocacy services for target communities: people of color, injection drug users, women and youth.
- ❑ Initiated Treatment Education Certification Program for the staff of community-based organizations.
- ❑ Continue to support needle exchange, which has been proven effective in preventing the spread of HIV and Hepatitis.
- ❑ Expanded culturally-competent peer advocacy programs.
- ❑ Completed research on transgender community's HIV risk; the study showed 35% prevalence overall and 63% among African-Americans.
- ❑ Initiated the first Action Point Center providing treatment adherence support to target communities including people of color, the homeless and the multiply diagnosed.
- ❑ Created a workplace re-entry program with the State Employment Development Department.

Homelessness

- ❑ San Francisco has a homeless population of approximately 7,000-8,000.
- ❑ The City has a 1% rental housing vacancy rate.
- ❑ Fires have destroyed a significant component of single occupancy hotels.
- ❑ Homelessness is linked to substance abuse/addiction, mental health, and chronic illness.
- ❑ An estimated 33% of homeless women and 15% of women living in shelters report sexual assaults.
- ❑ Approximately 23% of San Francisco General Hospital inpatient days are for homeless persons; many can not be discharged for recovery because of their lack of housing.

Homelessness Response

- ❑ The Department provides \$11.5 million in funding for housing assistance to 2,500 homeless and disabled persons annually.
- ❑ The Department has implemented a Direct Access to Housing program which provides housing to homeless in downtown hotels.
- ❑ Funding has been allocated to open the Pacific Bay Inn and Windsor Hotel for supportive housing for the homeless.
- ❑ The Department consolidated 3 emergency shelters into the Mission Rock facility.
- ❑ The San Francisco General Hospital Emergency Department High Users program coordinates health and social services for homeless persons to reduce their use of emergency care.

Mental Health

- ❑ The City has a higher prevalence of schizophrenia, bipolar disorder and major depression than California overall.
- ❑ Many health plans do not provide sufficient mental health benefits to diagnose and treat mental illness appropriately.
- ❑ An estimated 30-40% of SF's homeless population have psychiatric disorders and/or substance abuse problems.
- ❑ Serious mental disorders are strongly correlated to abuse of alcohol and/or drugs.

Mental Health Response

- ❑ DPH worked with the Department of Human Services to develop mental health treatment components of welfare-to-work programs
 - DPH provided mental health services to 910 Cal WORKS recipients and their children
 - Approximately 400 General Assistance clients will be served this coming year.
- ❑ The Department began operation of the San Francisco Mental Health Plan on April 1, 1998. The plan provides mental health benefits to all Medi-Cal beneficiaries and indigent clients.
- ❑ The Plan includes 120 mental health programs and 600 individual and group providers.
- ❑ Community Mental Health Services expects to serve 23,000 in FY 98-99.
- ❑ The Department has developed a consulting service to work with primary care physicians.

Substance Abuse

- ❑ Nationally, San Francisco ranks the highest of all US cities in 3 categories of drug-related ER admissions - amphetamines, LSD and heroin.
- ❑ San Francisco's three-year average age-adjusted death rate for drug related deaths is 19.3/100,000 population - the highest in the state.
- ❑ Every day in San Francisco there are 52 narcotic or alcohol related arrests.
- ❑ Over 1,000 San Franciscans are on the waiting list for substance abuse treatment services.

Substance Abuse Response

- ❑ Based on priorities established by the Treatment on Demand Planning Council, DPH added 658 substance abuse treatment slots in 1998-99 bringing total capacity to 13,046 slots.
- ❑ New youth services funded by a \$300,000 State grant will be established this year
 - multi-service youth center
 - employment readiness training
 - prevention and outpatient care
 - serving ages 12 -17
- ❑ New programs include
 - residential program for Latino men
 - treatment for families
 - treatment for prostitutes
 - social model detox with Tom Waddell Health Center.
- ❑ Created Certified Addiction Treatment Specialist program with SF City College.

Tobacco

- ❑ In San Francisco smokers include:
 - 12.5% of youth under age 18
 - 19.4% of 18-29 year olds
 - 19% of adults 30+ smoke.
- ❑ A random survey of San Francisco stores in 1997 found that 13% sold tobacco to minors; a follow-up survey in 1998 found that 15% did.
- ❑ A random survey in 1998 found 96.5% of restaurant bars in compliance with the smoke-free bar law while only 50.6% of stand-alone bars were complying.
- ❑ The Department received 200 complaints last year of violations for the “no smoking in bars” law.

Tobacco Response

- ❑ In 1998, the local ordinance banning outdoor tobacco ads took effect.
- ❑ Implemented a tobacco prevention program for youth through the tobacco suit Mangini settlement.
- ❑ The prevention program emphasizes enforcing sales to minors and reducing youth access to tobacco.
- ❑ DPH has created and operated a model smoke-free bar education and enforcement program.
- ❑ In response to complaints, 75-100 bars were inspected regarding illegal smoking and 60-75 citations issued.

HEALTH CARE DELIVERY ISSUES

Hospital Diversion

- ❑ In the last two winter seasons, San Francisco hospitals have increasingly diverted patients to other facilities because of increased demand.
- ❑ The downsizing of acute care beds and the nursing shortage contributed to the resource gap in San Francisco.
- ❑ Diversion disrupts continuity of care and jeopardizes the City's ability to respond to emergencies.
- ❑ There appears to be a continuing upward demand for emergency medical services in San Francisco.

Hospital Diversion Response

- ❑ After the winter crisis of 1997- 98, the Emergency Medical Services Agency initiated a planning process with the City's hospitals to prepare for the next winter season.
- ❑ Through the Receiving Hospital Liaison Committee, planning was implemented to respond to the high census again experienced in 1998-99. This included opening additional medical/ surgical and critical care beds.
- ❑ The EMSA is working collaboratively with the Hospital Council to improve the City's ability to manage emergency care and acute hospitalization.
- ❑ The Agency and the City's providers are jointly identifying system capacity, preparing for projected bed need and anticipating peak loads.

Long-Term Care

- ❑ By 2020, 23.4% of San Franciscans will be 65+ and 3.4% will be 85+.
- ❑ An estimated 6% of San Franciscans 18 - 64 and 22.9% over 65 years old have mobility or self-care limitations requiring long term care.
- ❑ There is a current deficit in skilled nursing beds in San Francisco
- ❑ By 2020, the deficit could grow to a shortage of 1,288 beds, even with increased community-based alternatives.
- ❑ Need to replace Laguna Honda Hospital to meet federal nursing standards and build seismically safe facility.

Long-Term Care Response

- ❑ The Long Term Care Integration Pilot Project was established under the State's AB 1040 program
 - planning to integrate and simplify access to medical and social services for long-term care
 - emphasizing a range of home, community-based, and institutional long-term care services
 - designing a service delivery system to enhance independence and quality of life, and to prevent or manage more serious disability or illness.
- ❑ The Laguna Honda Hospital Replacement Planning Committee advocates for construction of a new skilled nursing facility to care for 1200 residents.

Managed Care

- ❑ Intense competition on cost and slimming profit margins leave no room for unfunded patients or unprofitable services.
- ❑ Services not provided or paid for by HMOs often fall to the responsibility of Department of Public Health's safety net - e.g., mental health, substance abuse.
- ❑ Managed care needs to be assessed on its maintenance of community health.
- ❑ Coordination of physical health with mental health, substance abuse and social services needs to be improved.
- ❑ Collaboration of managed care with local health departments must be developed - to monitor/ track health status for health promotion and prevention.

Managed Care Response

- ❑ Continued concern about the long term viability of the two-plan model for Medi-Cal managed care.
- ❑ The City is considering a Medicaid 1115 waiver as a means of potentially implementing a revised model.
- ❑ The San Francisco Mental Health Managed Care Plan expects to eventually serve 25,000 annually - Medi-Cal and indigent clients.
- ❑ The San Francisco General Hospital Emergency Department High Users Program has implemented a case management approach to frequent ER users, coordinating their health and social services.

Health Care Coverage in San Francisco

- Coverage (755,000) - 1997
 - Employer-Based 52%
 - Privately purchased 6%
 - Medicare 15%
 - Medi-Cal* 10%
 - Uninsured 17%

*Total 100,500 Medi-Cal recipients in County; 27% of Medi-Cal eligibles are also receiving Medicare. The individuals are classified as having Medicare as primary source of coverage.

San Francisco's Uninsured

- ❑ A significant number of uninsured are working or are in families where there is a working adult.
- ❑ Uninsured (130,000)
 - Working Adults (full time, self employed, etc.) - 68%
 - Indigent Adults (General Assistance recipients, homeless, etc.) - 14%
 - Other Adults (low-income college students, non-working adults) - 8%
 - Children and Youth - 10%.
- ❑ The uninsured have limited access to regular routine preventative and primary care services.
- ❑ The health status of the uninsured is lower than that of those with health insurance.

Uninsured Response

- ❑ The Mayor's Blue Ribbon Committee on Universal Health Care proposed a plan to provide coverage to the City's uninsured.
- ❑ The voters of San Francisco overwhelmingly supported the concept of universal health coverage (Proposition J).
- ❑ The State's Healthy Families has been implemented and is enrolling low-income children. Current San Francisco enrollment is 4,180.
- ❑ The Department is participating in a Medi-Cal outreach project to identify and enroll families into the program.

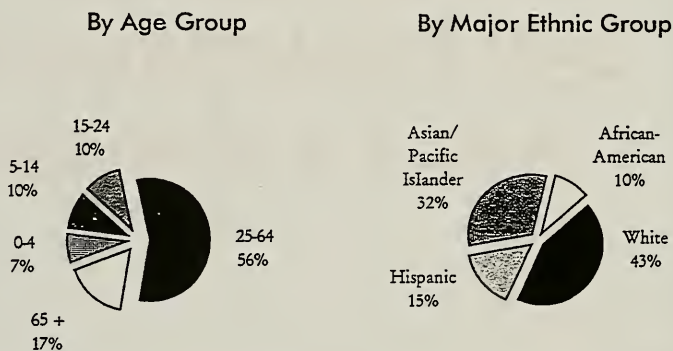


OVERVIEW OF SAN FRANCISCO'S HEALTH STATUS

Population: By Age Groups and Major Ethnic Groups

San Francisco's total population grew from 723,900 in 1990 to 768,263 in 1996, a 6.2% increase. San Francisco has a distinct demographic profile, including a smaller proportion of children and youth, a larger proportion of seniors, and a more ethnically diverse mix of inhabitants than the rest of California.

Population by Age Group and by Major Ethnic Group, San Francisco, 1996



Population Continued: By Major Ethnic Groups and Age

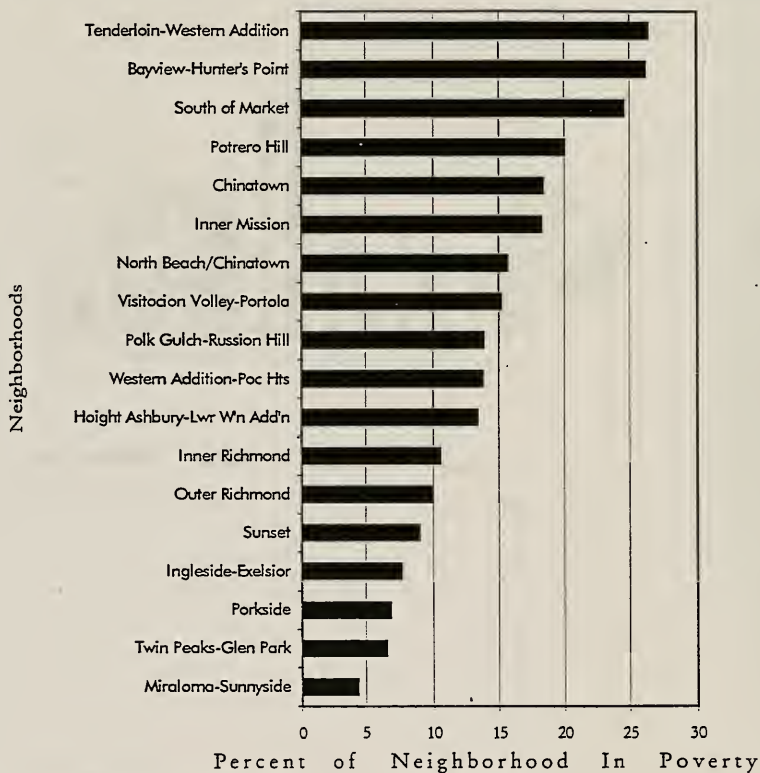
In comparison to other US cities, San Francisco has a relatively older population, with a larger proportion of its residents over 44 years old, and a smaller number of children and youth than other cities in California. This distribution is especially marked in the white population, but less so in other ethnic groups.



Poverty

Poverty and socioeconomic conditions are important components of any assessment of health status. Worse socioeconomic conditions have been shown to be associated with many types of poor health outcomes, poor nutrition, lack of access to adequate health care, and greater exposures to many kinds of physical, social, environmental, and behavioral risks.

Percent of People in Poverty by Neighborhood, San Francisco, 1990

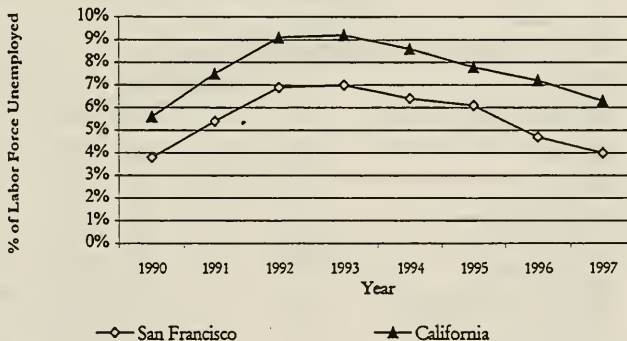


* Data collected by zip code

Unemployment

Unemployment rates reflect the number of people in the labor force who are both able to work and are actively seeking employment. These rates exclude people who are unable to work or have given up looking for work. Unemployment rates also give some indication of the socio-economic status of San Franciscans. In addition, unemployment has been linked with poor health outcomes and with lack of access to health insurance.

Unemployment Rates, San Francisco and California, 1990-1997



Leading Causes of Death: Age Adjusted Mortality Rates

Leading causes of death are a standard component of health indicator data, both because of death's obvious import and because mortality information is collected regularly for the entire population. Furthermore, HP 2000 objectives are set for many causes of mortality, which allow for national, state, and local comparisons.

Age Adjusted Mortality Rates for Leading Causes of Death, San Francisco, 1994-1996*

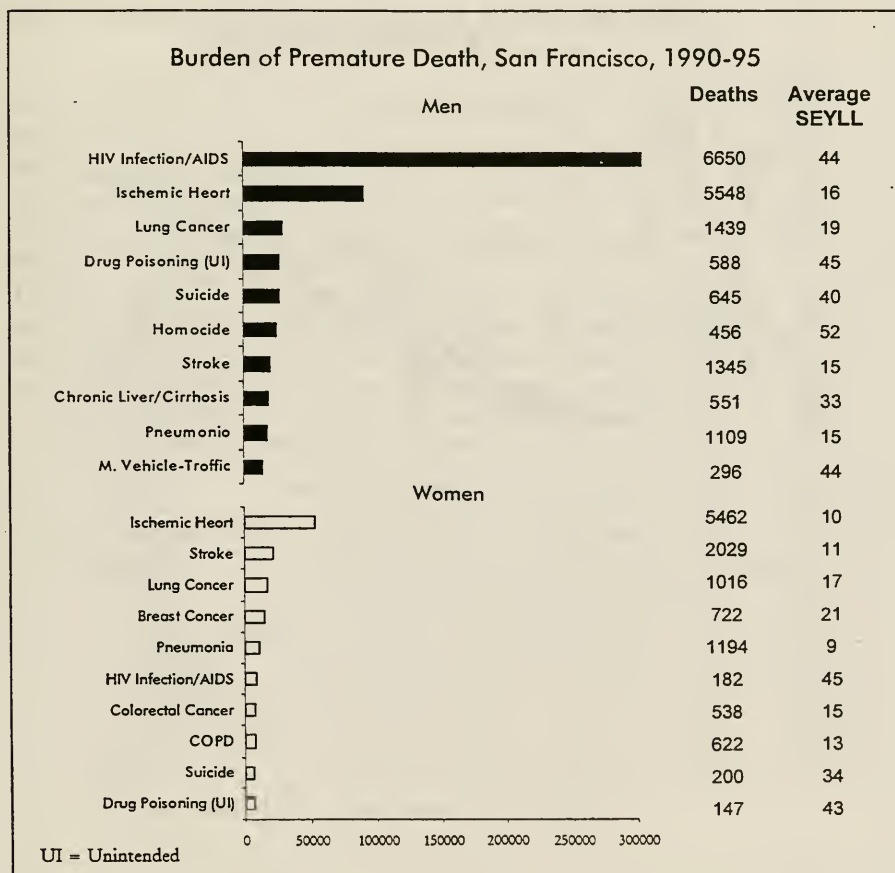
Indicator	SF Annual Average # of Deaths	SF Rate	CA Rate	HP 2000	HP 2000 Objective Met by SF?
All Causes	7735	547.1	454.2	-	No Objective
AIDS	965	104.4	16.9	-	No Objective
Coronary Heart Disease	1784	93.2	100.6	100.0	Yes
Stroke	556	26.8	26.3	20.0	No
All cancers	1573	112.5	115.9	130.0	No
Lung cancer	392	28.5	31.8	42.0	Yes
Breast cancer	106	15.2	19.7	20.6	Yes
Unintentional injuries	313	33.1	26.6	29.3	No
Motor Vehicle Crashes	66	8.0	13.2	14.2	Yes
Homicide	71	10.8	11.8	7.2	No
Suicide	140	15.7	10.7	10.5	No
Drug-related deaths**	186	20.5	8.0	3.0	No
Firearm injury deaths**	88	12.7	15.0	11.6	No

*Per 100,000 population

**Includes both intended (homicide, suicide, and legal intervention) and unintended

Leading Causes of Death Continued: SEYLL

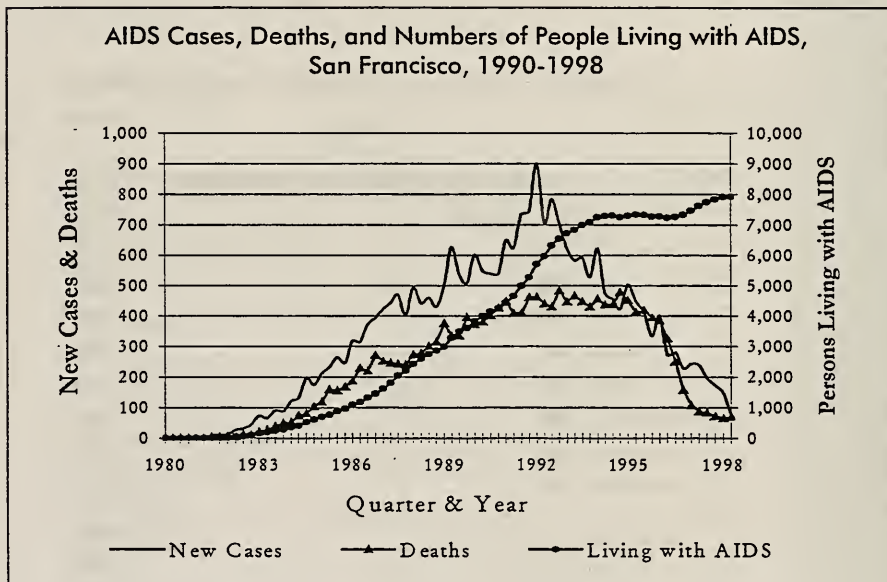
In San Francisco, the Department of Public Health also analyzes the leading causes of death by measuring Standard Expected Years Life Lost (SEYLL) for specific causes of death. By giving greater weight to deaths of younger people, this measure emphasizes premature mortality. The years of life lost for a person dying are based on life expectancy for persons of their age at the time of death. The average SEYLL indicates the average number of years of potential life lost by individuals who die from each of these causes of death. These data illustrate the overwhelming burden of AIDS-related deaths in San Francisco, as well as men's higher levels of premature death.



Source: *San Francisco's Burden of Disease: Mortality 1990-1995*. 1998. Community Health Epidemiology, San Francisco Department of Public Health, December 1998.

Communicable Diseases: AIDS

In 1990-95, AIDS was by far the leading cause of preventable death in San Francisco, as measured by expected years of life lost. Since 1980, there have been 25,494 reported AIDS cases and 17,573 deaths due to AIDS in San Francisco. The number of new cases and deaths peaked in the early 1990s, but the number of new AIDS cases has been declining since 1992, and the number of AIDS deaths has been declining since 1995. Due to improved treatment for those with HIV and AIDS, the number of people living with AIDS is rising.



Communicable Diseases: AIDS Continued

In San Francisco, AIDS has been and continues to be a disease predominantly of men who have sex with men. It does, however, affect people of all genders, sexual orientations, and ethnic groups. Recently, AIDS cases have been declining among all transmission categories and ethnic groups. AIDS cases have declined among women between 1992 and 1997, but have been stable in the period 1990-1997.

**AIDS Cases by Transmission Category, Ethnicity,
and Year of Diagnosis, San Francisco, 1990-1997**

	Number of Cases				Difference, 1990-1997	
	1990	1992	1995	1997	# of Cases	% Change
Transmission Category:						
Adult/adolescent						
Gay/bisexual men	1,861	2,438	1,269	617	-1244	-201.6
Injection drug users (IDU)	117	257	174	113	-4	-3.5
Gay/bi men + IDU	191	300	180	69	-122	-176.8
Lesbian/bi fem + IDU	3	7	5	1	-2	0.0
Heterosexuals	27	46	33	23	-4	-17.4
Transfusion	13	17	8	3	-10	-333.3
Pediatric (0-12 years)	3	2	1	1	-2	0.0
Sex:						
Male	2,169	2,971	1,606	790	-1379	-174.6
Female	60	122	89	60	0	0.0
Ethnicity:						
White	1,729	2,247	1,167	557	-1172	-210.4
African-American	227	367	252	146	-81	-55.5
Hispanic	194	377	209	114	-80	-70.2
API/other	64	77	59	30	-34	-113.3
Native American	15	25	8	3	-12	-400.0
Total:	2,229	3,093	1,695	850	-1379	-162.2

*1997 cases likely to be not completed reported at date of publishing.

Communicable Diseases: Sexually Transmitted Diseases

Rates of Sexually Transmitted Diseases (STDs) in San Francisco have decreased since the late 1970s. However, San Francisco rates are still well above those of California and the US as a whole. Although San Francisco has high overall rates of gonorrhea and infectious syphilis, we have met HP 2000 revised objectives for specific population groups for which there are objectives and for repeat gonorrhea and congenital syphilis.

Because gonorrhea testing has been relatively constant, and testing procedures have not changed substantially, gonorrhea may be the best STD for evaluating STD trends over time and by population. Gonorrhea rates in San Francisco are the highest in California and among the highest in the US. San Francisco rates are at least 4 times higher than California rates at 270 per 100,000 vs. 60 per 100,000 statewide. Furthermore, San Francisco rates are significantly higher than other urban areas such as New York City (at 180 per 100,000) and Los Angeles (at 70 per 100,000).

Selected STD rates (cases per 100,000 per year) compared with
HP 2000 Objectives, San Francisco, 1997

Disease	Number of Cases	SF rate	HP 2000 Objective	HP 2000 Objective Met?
Gonorrhea:				No
All Groups	1535	212.0	100	
African Americans	485	635.3	650	Yes
Asian	56	27.2	No Objective	–
Hispanic	130	129.1	No Objective	–
White	564	167.3	No Objective	–
Adolescents	134	358.7	375	Yes
Women 15-44	272	149.6	175	Yes
Repeat Gonorrhea	–	8.2%	15%	Yes
Infectious Syphilis	57	7.9	4	No
Congenital Syphilis	2	23.3	40	Yes

Communicable Diseases: Tuberculosis

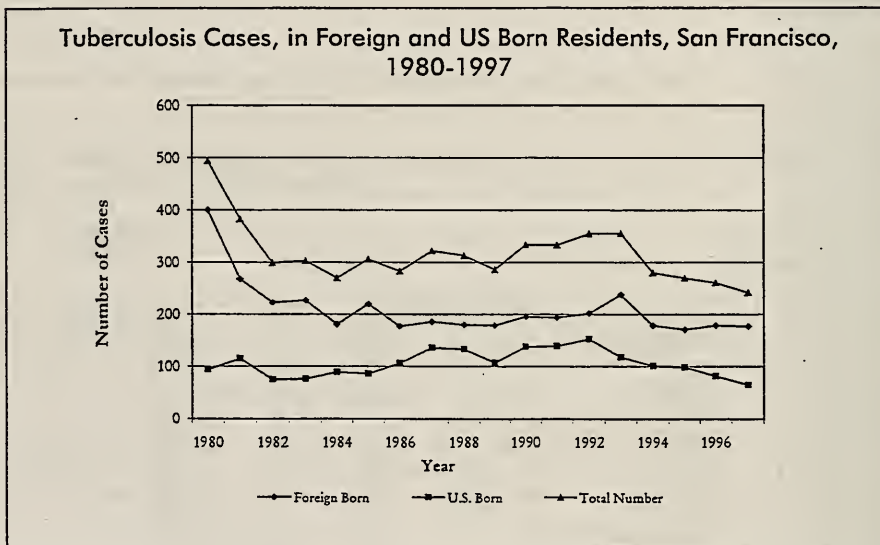
The number of Tuberculosis (TB) cases for 1997 was the lowest ever recorded in San Francisco's history. At the current pace, cases for 1998 will be even lower, resulting in the fifth consecutive year of decline in TB cases. The decrease has been largely due to the decline in TB among African-Americans and Whites, increased case finding, directly observed therapy (DOT), and increased prophylaxis against TB.

Tuberculosis Rates (cases per 100,000 population) San Francisco, California, and HP 2000, 1997

	SF		CA Rate	HP 2000 Objective Rate	Percent Change, San Francisco 1990-1997	Healthy People Objective Met?
	Rate	Number				
Tuberculosis Cases	37	242	17	3.5	-27.5%	No
Asian/Pacific Islanders	69.7	142	45.1	15.0	-8.0%	No
African-Americans	24.0	19	17.8	10.0	-64.1%	No
Hispanics	35.7	36	13.7	5.0	+8.8%	No
Whites	11.8	34	—	—	-56.3%	—
Preventive therapy completion*	90%	—	—	85%	—	Yes

Communicable Diseases: Tuberculosis Continued

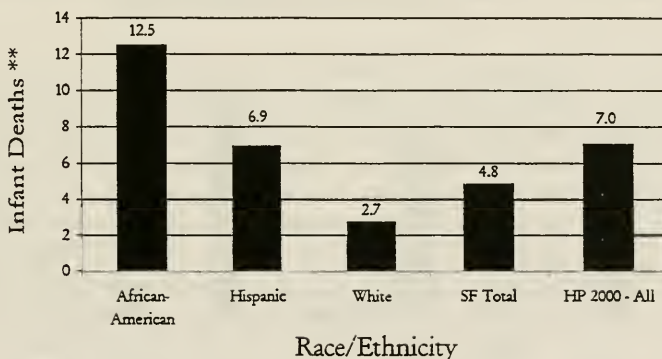
Despite promising statistics, the TB case rate in San Francisco remains well above the Healthy People 2000 objective of 3.5 cases per 100,000, and is 4 times the national rate and double the California rate. In 1998, through September, 70% of new active cases of TB occurred among foreign-born residents of San Francisco. The large majority of foreign-born cases occurred in Asian immigrants, predominately Chinese, Filipino and Southeast Asian. Since 1994, U.S. born cases have declined by about 35%.



Maternal and Child Health: Infant Mortality

Infant mortality is an important measure of a community's health and is recognized worldwide as a core indicator of a community's health status. In 1996 there were 40 deaths of infants less than 1 year old in San Francisco, resulting in an infant mortality rate of 4.8 per 1,000 live births. San Francisco has achieved the Healthy People 2000 goal of reducing the infant mortality rate to no more than 7 per 1,000 live births.

Infant Mortality Rate, By Race/Ethnicity, San Francisco, 1996*

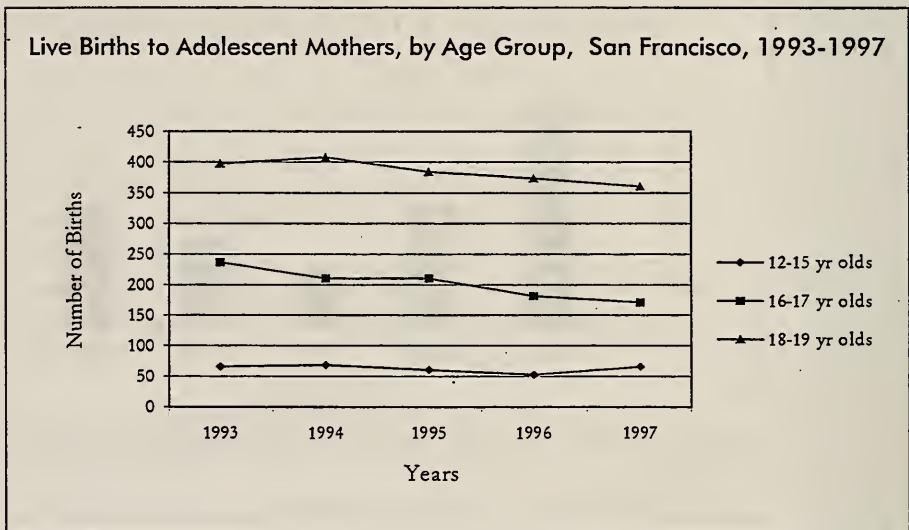


* Rates of infant death not calculated for < 100 births, for categories with fewer than five deaths, or for missing race/ethnicity

** Per 1,000 live births

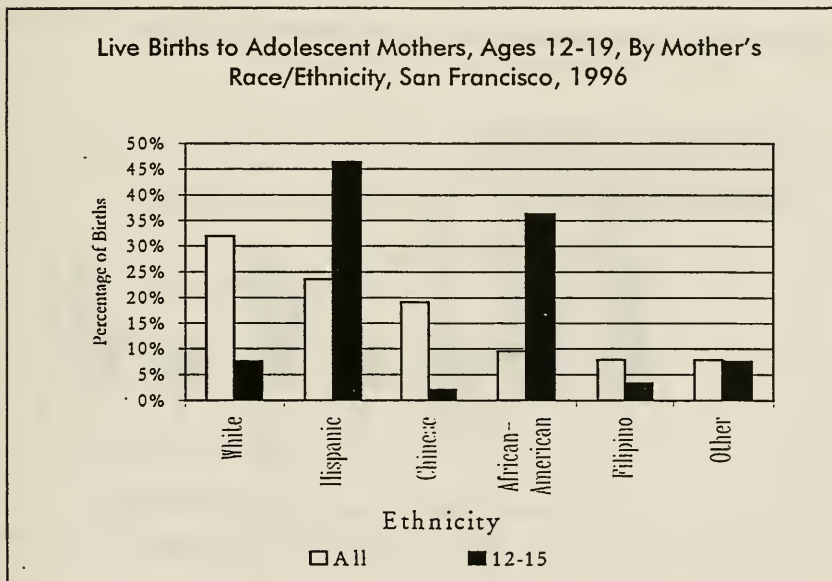
Maternal and Child Health: Adolescent Childbearing

Adolescent childbearing has important health and social consequences for young women, their babies, and their families. Pregnant adolescents are more likely to have inadequate prenatal care. The younger the adolescent mother, the more likely she is to have poor pregnancy outcomes such as preterm delivery and a low birthweight infant, and to be chronically poor as an adult.¹



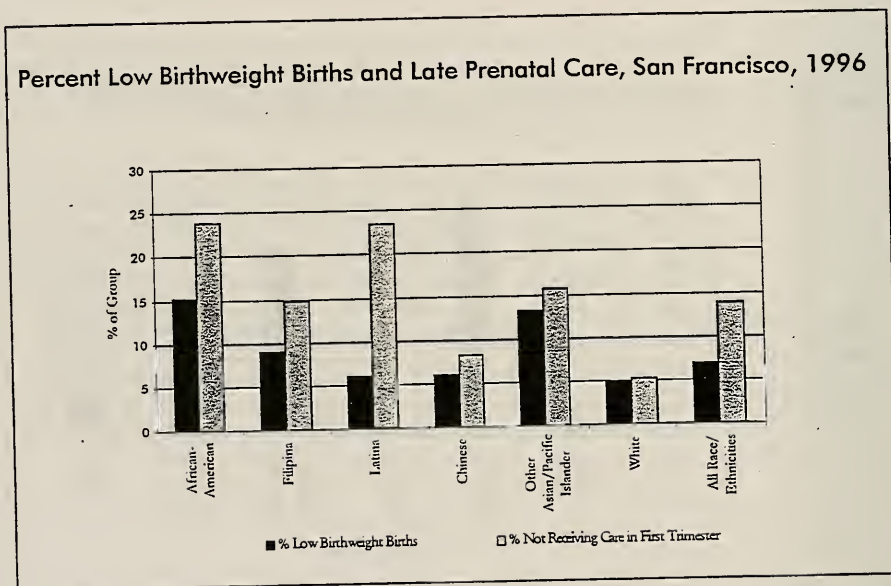
Maternal and Child Health: Adolescent Childbearing

African American and Hispanic adolescents account for a disproportionate share of births to adolescent girls as compared to the distribution of all births in San Francisco by race and ethnicity.

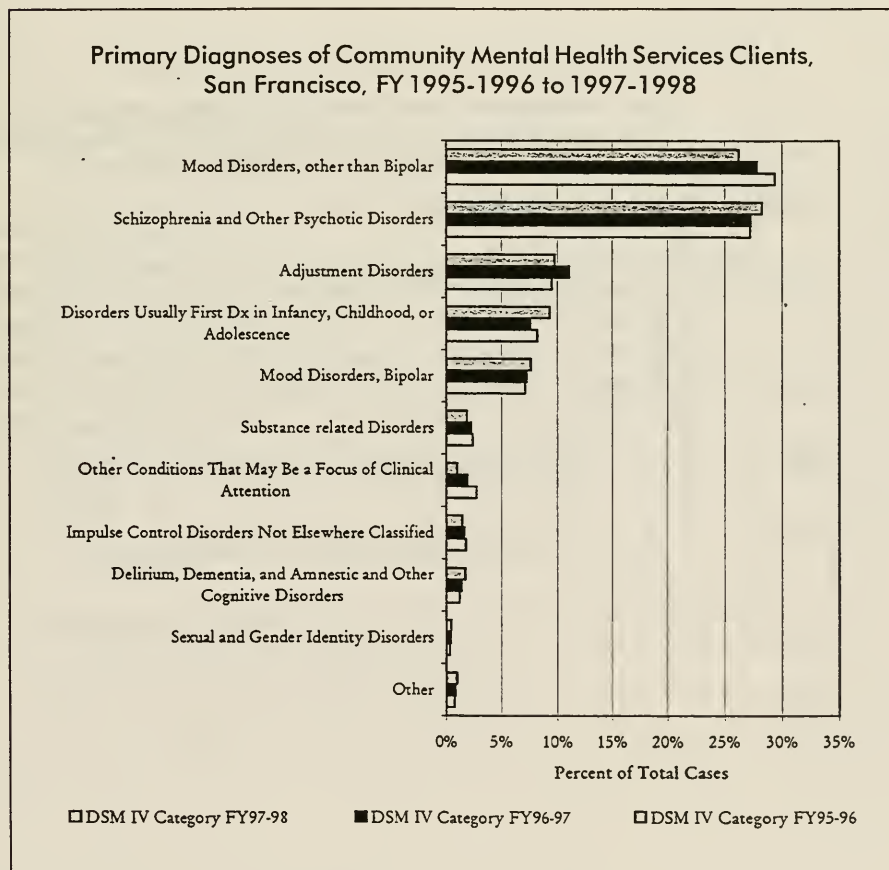


Maternal and Child Health: Birthweight

Birthweight serves as a marker for health status of infants. Low birthweight infants (under 2500 grams or 5.5 pounds) are at a higher risk for physical and developmental complications and infant mortality. Low birthweight is often associated with late or no prenatal care, poor maternal nutrition, maternal smoking, preterm delivery, and other conditions.

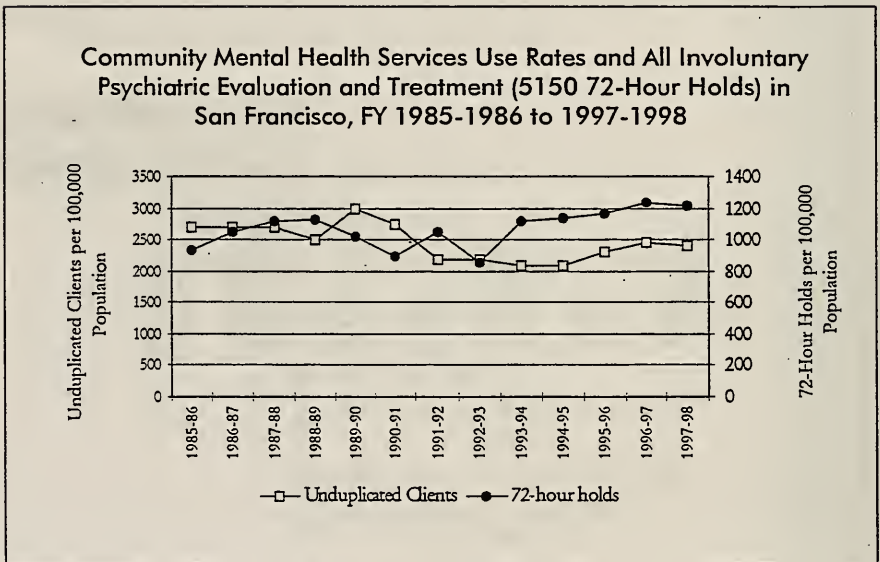


The Community Mental Health Services of the San Francisco Department of Public Health primarily treats those with severe mental illness, which is reflected in the diagnoses of clients. These data are consistent with the rest of the country for jurisdictions addressing the needs of the severely mentally ill. No recent data are available on the overall level of mental health conditions and needs in the population at large in San Francisco.



Mental Health Continued

Although the overall number of mental health clients has declined, the acuity of mental illness may have increased, based on the rise in the number of "5150" 72-hour holds in the City as a whole. According to state law, individuals who are a danger to themselves or others or are greatly mentally disabled may be detained for up to 72 hours for evaluation and treatment.



Alcohol, Tobacco, and Other Drugs: Substance Abuse

Alcohol, tobacco, and other drugs contribute to a large proportion of San Francisco's leading causes of death. Roughly one fifth of all mortality in the City can be attributed to alcohol or tobacco alone.²

Substance Abuse Indicators, San Francisco, 1993-1998

Impact of Substance Abuse	
SF has the highest rate of drug related deaths in CA, 1993-1995:	20 per 100,000
S.F. has the highest rate of methamphetamine emergency room visits in the U.S., 1996:	38 per 100,000
S.F. has the highest per capita concentration of retail liquor licenses in CA, 1997:	492 per 100,000
Substance Abuse and Homelessness	
Percentage of S.F. homeless deaths (n=104) directly caused by alcohol or drugs, 1997:	56%
Percentage of S.F. drug-caused homeless deaths involving heroin, 1997:	89%
Percentage of homeless street youth ever using heroin, speed or cocaine, 1993-95:	75%
Injection Drug Use	
Injection Drug Users (IDUs) living in S.F., 1997:	17,100
IDUs in treatment programs, Fiscal Year 1997-98:	4,800

Alcohol, Tobacco, and Other Drugs: Substance Abuse

In addition, alcohol, tobacco and other drugs play a key role in the amount and severity of disease and injury in San Francisco. Drug overdose, primarily with heroin or cocaine, is San Francisco's fifth leading cause of premature death.³

Substance Abuse Indicators, San Francisco, 1996-1998

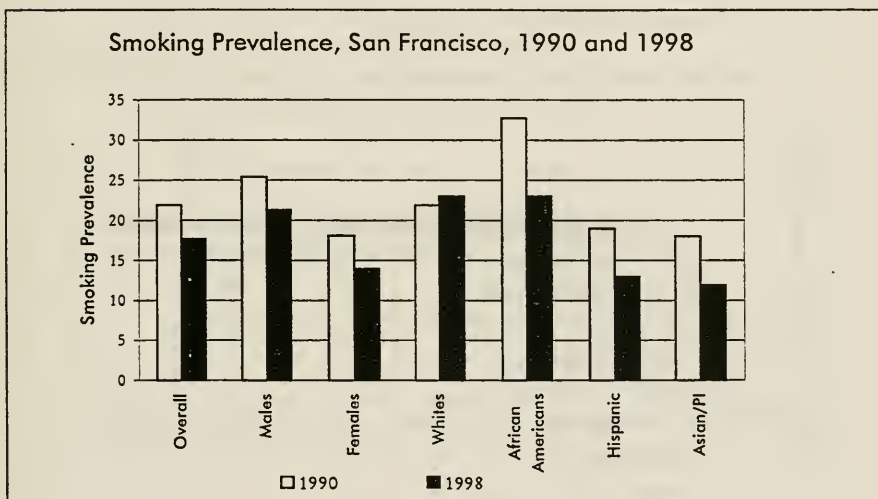
	Heroin	Cocaine	Speed	Marijuana	Alcohol
CSAS Clients in Treatment, FY 97-98*	4,026	2,865	1,140	729	3,234
Drug-Caused Deaths, FY 96-97	107	83	22	—	—
Students Using Monthly, 1997	—	3%	—	18%	30%
Emergency Room Drug Related Visits, 1996	3,491	2,540	1,031	464	—
Alcohol and Drug Arrests, 1997**	6,546	1,504		1,995	5,952

*Unduplicated ; Total Number of Clients in Treatment: 12,679

**Cocaine and Speed counted as a single category in current data

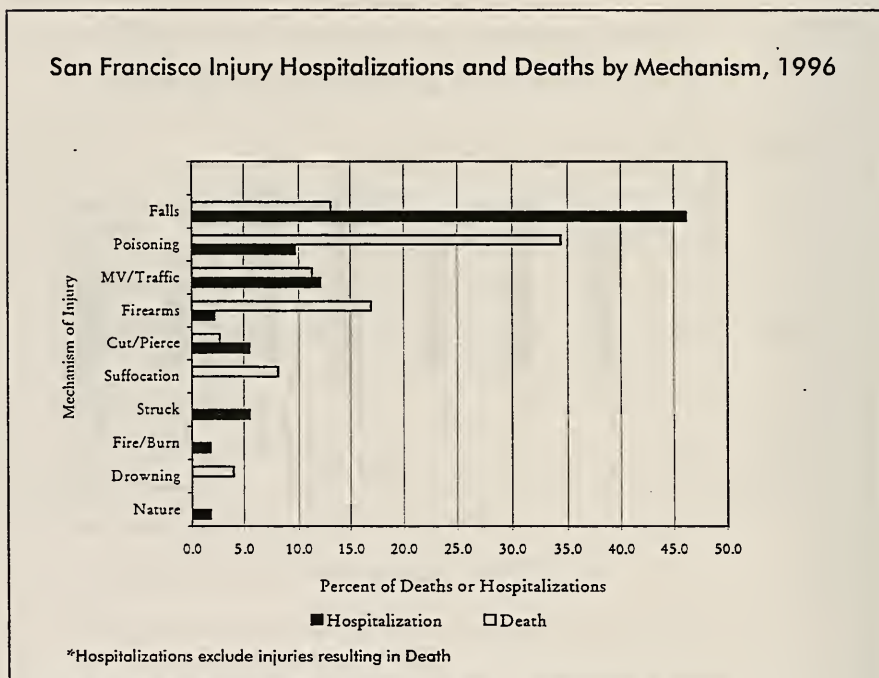
Alcohol, Tobacco, and Other Drugs: Tobacco

From 1990-1995, roughly 10% of mortality in San Francisco was attributable to tobacco.⁴ Since 1990, smoking rates in San Francisco have decreased, overall and in all ethnic groups except whites. In 1998, 16% of 334 randomly-selected San Francisco tobacco vendors illegally sold tobacco to people under the age of 18 years old. These data indicate that tobacco is readily available to youth.



Injuries: Hospitalizations and Deaths

Injuries account for a significant proportion of the deaths, hospitalizations and emergency responses in San Francisco. A large share of these injuries is preventable.



Injuries: Domestic Violence

Domestic violence can occur in any type of relationship, between people of any gender, age, socioeconomic status or ethnicity. Domestic violence is difficult to measure as it often goes unreported and/or unrecognized, and health care providers often do not ask about it.

Domestic Violence Intervention in San Francisco General Emergency Department (SFGHED), 1998

Persons admitted to SFGH ED, for any reason (per year):	
Total:	70,000
Women:	25,000
Men:	45,000
Percent of those admitted to SFGH ED who were experiencing abuse by their "significant other:" *	
Women:	12-14%
Men:	3%
MSM (Men who have sex with men:)	14% of MSM
*Study participants were asked their own sexual preference, if they were experiencing abuse, and if so, if the abuser was their significant other. Data presented here is preliminary; additional information will be analyzed.	

Environmental Health: Air Quality

The environment in which San Franciscans live and work can have a significant impact on their health. Three of the indicators the San Francisco Department of Public Health uses to assess the quality of our physical environment are air quality, solid waste generation, and elevated blood lead levels.

The Federal Clean Air Act directs the EPA to develop and promulgate health based standards for certain "criteria" ambient air pollutants including ozone, respirable particulate matter (PM₁₀), sulfur dioxide, nitrogen dioxide, carbon monoxide, and lead. Since 1993, the state air pollution standards for ozone, carbon monoxide, nitrogen dioxide and sulfur dioxide have not been exceeded in San Francisco. However, there have been several occasions on which daily concentrations have been higher than the 24-hour PM₁₀ (particulate matter) standard. In the Bay Area, major sources of PM₁₀ include industrial emissions, motor vehicles, road dust, construction, demolition and residential wood smoke.⁵

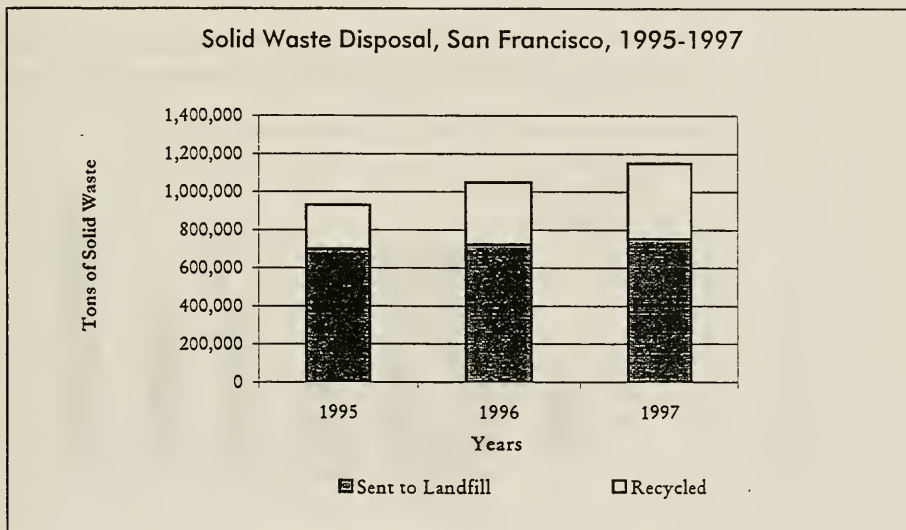
**California Air Pollutant Standards and Maximum Concentrations
San Francisco, 1993-1997 ***

Pollutant	California Standard	Measure	1993	1994	1995	1996	1997
Ozone	9 pphm	1 hour max.	8	6	9	7	9
Carbon Monoxide	9 ppm	8-hour ave.	4.8	4.4	4.4	3.7	4.2
Nitrogen Dioxide	25 pphm	1-hour max.	8	9	9	8	7
Sulfur Dioxide	50 ppb	24-hour ave.	9	5	7	8	6
PM ₁₀	30 µg/m ³	Annual mean	25.1	24.7	22.1	21.4	22.5
	50 µg/m ³	Highest 24-hour ave.	69	93	29.9	70.9	81.0

*Concentrations are averaged across all city monitors.

Environmental Health: Solid Waste

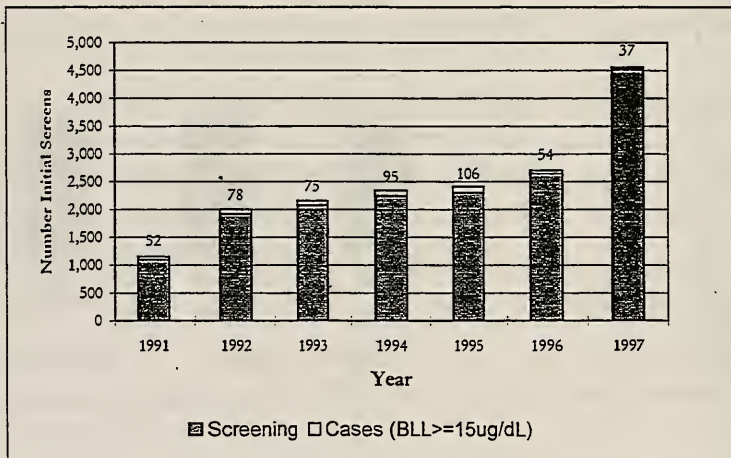
Over the last three years, the amount of waste produced in San Francisco has increased. This increase may be attributable to the growing economy, including increased construction, tourism, and consumption. However, the City's recycling efforts are paying off; a greater percentage of the generated waste is being diverted from landfills and recycled. In 1997 5.34 pounds per person in San Francisco were sent to landfill, still above the Healthy People 2000 goal of 3.2 pounds per person. However, this per capita rate includes waste from San Francisco's numerous non-resident workers and tourists.



Environmental Health: Lead

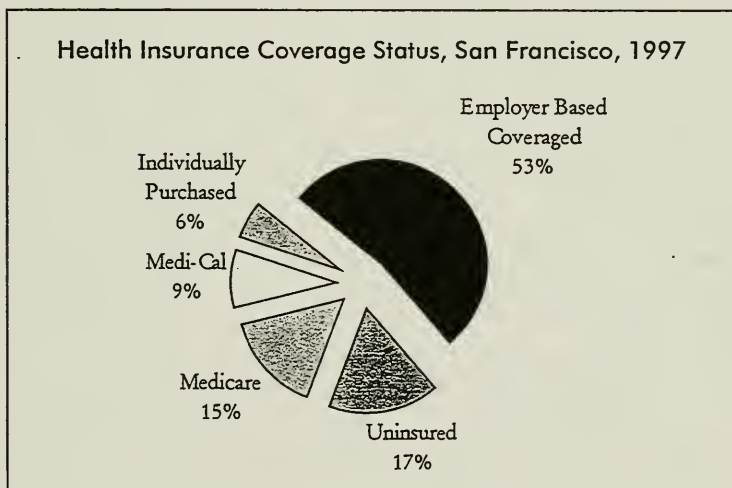
Lead screening of children seen by San Francisco providers has increased considerably since 1991. From 1991 to 1997, 7.0% of children screened had initial blood lead levels that were elevated above the Centers for Disease Control (CDC) level of concern ($\geq 10\mu\text{g/dL}$), and 3.0% of screens had blood lead levels requiring case management services ($\geq 15\mu\text{g/dL}$). The most common environmental source of lead for San Francisco children with elevated blood lead levels were lead-based paint, lead-contaminated soil, and lead dust. While the numbers of children screened has increased, the number of children found to be cases has been dropping (-2.0% in 1996 and -0.8% in 1997). The decline in cases over years follows national trends.

Children 0-5 Years Old Screened and Reported with Elevated Blood Lead Levels, Participating Providers, San Francisco, 1991-1997



Access: Health Insurance Coverage Status

Inadequate access to health care is a significant problem in San Francisco (as it is elsewhere in California and the rest of the US), as it is related to lack of preventive care, higher rates of preventable disease and injuries, and poorer health outcomes from illness and injury. San Francisco's uninsured population follows a state-wide pattern in that the great majority of uninsured are workers (full or part-time) or are members of working families.⁶ The measure of San Franciscans with health insurance is commonly used as an indicator of access to health services.



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- ⁶ San Francisco Department of Public Health, *Achieving Health Insurance for San Francisco's Uninsured: A Report of the Mayor's Blue Ribbon committee on Universal Health Care*. May 1998. P. 1.

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Mitchell H. Katz, M.D.
Director of Health
San Francisco
Department of Public Health
May 1, 2000

*The mission of the
San Francisco
Department of Public Health
is to promote and protect
the health of all San Franciscans.*



Mitchell H. Katz, MD
Director of Health

2000 STATE OF THE CITY PUBLIC HEALTH ADDRESS

President Ammiano and members of the San Francisco Board of Supervisors thank you for the opportunity to speak to you today on the state of public health in our City.

When I meet with health officials from other localities, I realize how lucky I am to be the Health Director in San Francisco, a city where the Board of Supervisors and the Mayor truly understand the needs of public health.

If money speaks louder than words, than the support of Mayor Brown and this Board of Supervisors has been thunderous. While other county health departments have had to cut back their services to cope with decreased Federal and State reimbursements, Mayor Brown and this Board have increased the City's general support of the Health Department by one hundred million dollars over the last three years. This infusion of funds has protected the City's delicately woven safety net.

Unfortunately, the Health Department faces unrelenting decreases in Federal and State revenues. The reason that the Federal and State governments have posted huge budget surpluses, is that they have pushed the cost of health care for poor people to counties. Sadly, in other counties people go without the health care that they need. Your financial support has made it possible for this care to be provided by our Health Department.

Compounding the problem of decreased revenue has been an increased demand for services. Throughout the State of California the number of uninsured persons has increased. This has occurred because the growth in the California economy has resulted in more people working, but working for employers who are not providing health insurance. They earn too much to qualify for Medicaid, but not enough to afford private health insurance. These people, the working poor, are our responsibility. In addition, the epidemics of HIV/AIDS, substance abuse, mental health and homelessness result in an increasing number of complex patients who, when they become ill due to medical illness, require prolonged hospital stays. A study of homeless persons in New York City published in the New England Journal showed that homeless persons had hospitalizations twice as long as housed persons for the very same illnesses. You do not need to be a health economist to know that decreased revenue and increased need spells financial ruin for a department such as ours.

Although the illness infecting safety net health providers like ourselves is very severe, I believe the prognosis is good. On the revenue side there is a growing recognition on Federal and State levels that some of the surpluses must go to resuscitating county safety net providers. My staff and I are working hard advocating for these changes on a State and Federal level. The growing dissatisfaction with managed health care, I hope, will fuel a national movement to a single payer health insurance program.

In the area of caring for patients with complex needs, I believe San Francisco can be a leader. We were, after all, the city that developed extensive community-based services to prevent the need for costly hospitalization for people with HIV/AIDS. We are the city that has driven down the rates of tuberculosis among homeless individuals and the city that never experienced the epidemic of

multidrug resistant tuberculosis, because we went out to peoples' homes and SRO hotels and soup kitchens and made sure they took their tuberculosis medications. Our affiliation with the University of California San Francisco puts San Francisco General Hospital at the forefront of efforts to provide the best possible care for medically and socially complex individuals.

By necessity the care for socially and medically complex individuals will be different than for those with isolated medical needs: let me illustrate. A typical San Francisco General Hospital patient is a middle-aged male with a history of substance abuse and mental illness who has lived on and off the streets of San Francisco for years. I have taken care of this man, over and over again, since I started working at San Francisco General Hospital in 1986. Sometimes he is African-American, sometimes he is Asian, sometimes he is Latino, sometimes he is White. Occasionally (although less often) he is female. But he is always poor. He requires frequent emergency department visits and prolonged hospitalizations. He is a heavy smoker and has chronic obstructive pulmonary disease. As you or I might, he sometimes develops pneumonia. Many people with pneumonia can be treated in their homes with strong oral antibiotics. He has no home. He will always need to be admitted to the hospital. Even people with homes sometime need hospitalization when they have serious symptoms. However, after four or five days of intravenous antibiotics they can generally be discharged. Because of his heavy smoking, his pneumonia is always slow to resolve. Even after several days of intravenous antibiotics he is not strong enough to go back out on his own. During one of his typical hospital stays, we spend about \$15,000 on him, yet we do not materially change this man's life.

My goal is to do better for this man and for the others like him. To do so, we must move our system, which is heavily oriented towards acute hospitalization, toward a broader continuum of

community-based services. In this time of decreased Federal and State revenues, I cannot allow the hospital services to soak up all of the money. I must put more money into community-based alternatives and prevention.

That is the reason that our health department has become the only health department in the country to master lease rooms in single occupancy hotels and provide supportive services in those settings for our patients. This past year we have opened the Pacific Bay Inn and the Windsor Hotel. With your help we will open the LeNain Hotel for homeless seniors. Although some believe that the job of housing individuals should not be that of a public health department, our department is the one with the most direct financial interest in providing housing. If my patient were housed, he would need fewer emergency department and hospital admissions.

My patient needs substance abuse treatment services. I am proud that since its inception in 1996-97, our Treatment On Demand Initiative has increased treatment slots by 1,974. Despite this increase in treatment slots my patient has been on the waiting list for methadone maintenance for months. With your help, we will increase methadone maintenance slots in the next year.

Sometimes my patient is hospitalized due to a soft tissue infection common among injection drug users. In 1998-99, San Francisco General Hospital saw an average of 12 patients a day for soft tissue injury and spent over \$18 million to provide care to these patients. An outpatient program will be developed that will improve their access to care and reduce the cost of it.

My patient needs mental health treatment. I'm pleased that over the last five years, our Community Mental Health Services Section has successfully reshaped the delivery of community

mental health services, emphasizing case management and outreach services. This has enabled us to reduce the number of hospital days. There is more that we can do. My patient should never be kept in an acute care psychiatric ward longer than he needs to be. When he is no longer acutely psychotic, he should be moved to a more appropriate setting.

Sometimes, even after an extended hospital stay, my patient is not well enough to be released. At such times I am thankful that Laguna Honda Hospital exists to provide rehabilitation for him. I am grateful to the members of the Board and the San Francisco voters who strongly supported rebuilding Laguna Honda Hospital. However, as with inpatient psychiatric services, my patient should never be cared for at Laguna Honda Hospital if he can thrive in a less restrictive community-based setting. That's why we are working closely with the Department's Long Term Care Planning Task Force and with advocates for the elderly and disabled, to insure a variety of community-based alternatives.

Although for my patient, it is too late for primary prevention and early intervention, his children and their children should not endure the same pain as he has. We must work to prevent disease. For that reason, despite the decreased revenue my department is receiving, we are increasing our financial support for prevention. We have partnered with the community to open the Bayview Hunter's Point Health and Environmental Resource Center. The Center will address breast cancer, asthma, prostate cancer and the environment. We are augmenting community-based and individual-based prevention services, such as the African-American Health Initiative, children's mental health and tobacco control. We are also expanding our adult immunization clinic. Because several diseases are preventable through immunizations. While our school system

insures that children are vaccinated by the time they are of school age, there is no system to insure that adults avoid diseases like hepatitis A and B. That is why we created the clinic.

Despite our fiscal challenges, we will never abandon our goal of improving health by expanding services, planning new initiatives, and focusing on health promotion and prevention. I would like to recognize my staff and their commitment to providing services in a professional, respectful and culturally competent manner. With our job freeze, many of my staff perform two and three jobs, and I am proud of them and grateful to them. I would also like to acknowledge the San Francisco Health Commission for their vision and leadership on health issues.

Thank you for the opportunity to speak to you today regarding the public health of our city. The attached written report provides additional information. I look forward to working with you over the next year to fulfill the Department's mission of protecting and promoting the health of all San Franciscans.

Department of Public Health
Efforts to Address
Selected Public Health Issues

Public Health Issues

- ❑ San Francisco's major public health challenges:
 - homelessness and lack of affordable housing
 - aging population with increasing long-term care needs
 - high substance abuse/addiction
 - high prevalence of mental health problems
 - high number of uninsured
 - high prevalence of HIV/AIDS
 - a high proportion of injuries and deaths that could be reduced by prevention
 - disparities in the health status and access to health insurance of different racial and ethnic communities
 - high incidence of some communicable diseases (e.g., tuberculosis, gonorrhea)
 - environmental health concerns

Leading Causes of Premature Mortality by Sex, San Francisco 1998

1998 Rank	Cause of Death	Expected Years of Life Lost	Deaths	Average Expected Years of Life Lost	1997 Rank
MALE					
1	Ischemic heart disease	12,340	839	14.7	1
2	HIV infection/AIDS	6,625	163	40.6	2
3	Drug poisoning, UI	5,207	119	43.8	4
4	Lung cancer	3,525	200	17.6	3
5	Lower resp. (Pneumonia)	2,965	232	12.8	7
6	Cerebrovascular (Stroke)	2,926	203	14.4	5
7	Suicide	2,890	73	39.6	6
8	Homicide	1,986	37	53.7	9
9	Chronic obstr. pulm. diseas	1,880	136	13.8	*
10	Inflam/infect/cardiomyop	1,820	74	24.6	*
FEMALE					
1	Ischemic heart disease	8,165	852	9.6	1
2	Cerebrovascular (Stroke)	3,052	297	10.3	2
3	Breast cancer	2,499	115	21.7	3
4	Lung cancer	2,239	138	16.2	4
5	Lower resp. (Pneumonia)	2,192	275	8.0	5
6	Drug poisoning, UI	1,153	24	48.0	7
7	Chronic obstr. pulm. diseas	1,074	87	12.3	9
8	Colorectal cancer	997	80	12.5	6
9	Diabetes mellitus	765	58	13.2	8
10	Genito-urinary diseases	764	72	10.6	*

* Not in 1997 top 10 causes of premature mortality

Homelessness and Housing

- ❑ Lack of affordable housing poses a significant barrier to improving the health status for indigent residents.
- ❑ Homeless patients made up 31% of patient days at San Francisco General Hospital.
- ❑ The City's low vacancy rate and high cost housing market result in extreme competition for purchase of available properties creating a significant barrier to providers interested in developing supportive housing programs.
- ❑ The Mayor's Office on Homelessness is undertaking an updated count of the City's homeless population.

Homelessness and Housing Response

INCREASED RELIANCE ON HOUSING ALTERNATIVES

- As the Department strives to rely less on institutional care, Housing Services is increasingly acting as a link between our hospital-based delivery system and the development of community-based alternatives.
- The Department provides approximately \$11.5 million in funding to assist over 2,500 people through emergency housing, rent subsidies and services linked to transitional and permanent housing.

DIRECT ACCESS TO HOUSING

- This project provides supportive housing for chronically homeless people who have been revolving through the streets and emergency care settings such as shelters, emergency rooms, jails and other institutions.
- The Department leases the Pacific Bay Inn and the Windsor Hotel which combined provide 170 units. Currently, all units in both hotels are full.
- In the new fiscal year the Department anticipates starting its third Direct Access to Housing Program project, the Le Nain Hotel. The hotel has 92 units and will target homeless seniors.

SHORT-TERM STABILIZATION PROGRAM

- Housing Services has teamed up with the Department of Psychiatry to establish 30 additional beds to provide stabilization services following a discharge from SFGH. Projected start-up for this project is January 2001.

REDESIGN OF AIDS EMERGENCY HOUSING PROGRAM

- Housing Services has convened a working group to improve longer-term stability of emergency housing for people with AIDS.

Long-Term Care

- ❑ Elderly and disabled need access to a wider range of social and medical support services.
- ❑ In San Francisco County, licensed community care residential facilities provide 1,071 beds in Adult Residential Facilities, and 2,530 beds in Residential Care Facilities for the Elderly.¹
- ❑ Two years ago there were 3,625 nursing facility beds in San Francisco.² Today there are 3,445 beds or a reduction of 180 beds.

¹ California Department of Social Services, Community Licensing Division, Licensing Information System, Directory Report, March 2000.

² San Francisco Nursing Facility Bed Study.

Long-Term Care Response

NON-INSTITUTIONAL LONG-TERM CARE SERVICES NEEDS

- ❑ To prepare for the needs of an aging population the Department continues to expand its home care program. Department transitional housing units are also being expanded so that people in hospitals and skilled nursing facilities can be discharged back into the community.

ASSISTED LIVING NEEDS

- ❑ The Department is expanding assisted living options and other alternative methods of care. The Laguna Honda Replacement Project under Proposition A will include 140 assisted living units.
- ❑ In addition, the Department supports and will expand its Adult Day Health Care Programs and Senior Nutrition Programs in the new skilled nursing facility.

SKILLED NURSING SERVICES NEEDS

- ❑ During the past year the need for long-term care services has been advocated by disabled and independent living representatives, community groups, consumers, and providers. Long-term care needs have also been documented in reports by the Long-Term Care Task Force and the Laguna Honda Hospital Replacement Project.
- ❑ The Department with the support of the entire San Francisco community, completed a significant accomplishment with the successful passage of Proposition A in November of 1999. The passage of Proposition A guarantees the replacement of Laguna Honda Hospital and Rehabilitation Center and the development of assisted living units on the campus.

Substance Abuse

- ❑ San Francisco's three-year average age adjusted death rate for drug-related deaths from 1996 to 1998 is 18.1 per 100,000 population. This rate is the highest in the state and well above the California state average rate of 7.5.¹
- ❑ During FY 1998–1999, 4,700 injection drug users (IDUs) with soft tissue infections were seen at San Francisco General Hospital Emergency Department. Of those 4,700, 40% were admitted with an average charge per admission of \$12,000.
- ❑ However, San Francisco's heroin-related hospital admission rate and heroin-related death rate are still three times higher than the California state average.²
- ❑ While in past years San Francisco ranked the highest nationally in heroin-related ED admissions, last year San Francisco dropped to number four in the country due to Treatment on Demand.
- ❑ Injection drug use, the dominant method of heroin use in San Francisco, is associated with significant health risks. It is estimated that over 90% of San Francisco's IDUs are infected with Hepatitis C virus (HCV).³
- ❑ Approximately 19.6% of San Francisco's estimated 17,100 IDUs are infected with HIV.⁴

¹ California Department of Health Services, County Health Status Profiles, April 2000.

² Cunningham J.K., Thielemeyer M.A., et al., "Heroin/Opioid-Related Hospital Admissions: Trends and Regional Variations in California (1986-1995)," Public Statistics Institute, Irvine, California, (1997).

³ Dr. Brian Edlin, Urban Health Study. Presentation to Patient Population Subcommittee, 12/16/98.

⁴ Community Substance Abuse Services (CSAS), Epidemiology, San Francisco Department of Public Health.

Substance Abuse Response

SERVICE EXPANSIONS

- Community Substance Abuse Services (CSAS) enhanced services in existing programs for people with multi-disorders including substance abuse problems, HIV and mental illness.
- Substance abuse treatment in the County Jails has been expanded.
- Three federal grants have been received for expansion of medically supported detoxification, outcome research, and expansion of methadone treatment for a total of \$2.5 million.

GROWTH IN YOUTH SERVICES

- Two community based organizations have been selected to open youth service centers in the Spring of 2000. Programs will provide substance abuse treatment and outreach services to at-risk for, or engaged in, substance abuse activities.

IMPROVED ACCESS FOR LATINO POPULATION

- The first residential substance abuse treatment program for mono-lingual Spanish speaking clients has opened.

STREAMLINED CARE FOR INJECTION DRUG USERS WITH SOFT TISSUE INFECTIONS

- The Department is developing a program to streamline care for Injection Drug Users (IDUs) with soft tissue infections through an outpatient Wound Center located at San Francisco General Hospital.
- Services will include surgical incision and drainage, pain management, substance abuse counseling, and wound care follow-up.

Substance Abuse Response

EFFORTS TO ADDRESS SAN FRANCISCO'S HEROIN EPIDEMIC

- ❑ Goal: To expand methadone maintenance treatment access for heroin addicted clients in order to reduce the morbidity and mortality of the users and to help prevent the potential spread of communicable diseases.
- ❑ In mid-April 2000, the Department will begin a 12 month feasibility study on office-based opiate addiction treatment. The study will develop recommendations on assessment and enrollment of patients, fiscal analysis and options for third-party reimbursements for specific services.

Tobacco

- ❑ In San Francisco smokers include:
 - 12% of middle school students,
 - 19% of high school students and
 - 17.7% of adults.
- ❑ A random survey of San Francisco stores in 1999 found that 15.7% sold tobacco to minors.
- ❑ Twenty percent (20%) of San Francisco's children and adolescents are exposed to environmental tobacco smoke in the home.
- ❑ A random survey in 1999 found 91.4% of restaurant bars in compliance with the smokefree bar law while only 39.7% of stand-alone bars were in compliance. In 1998, 96.5% of restaurant bars and 50.6% of stand-alone bars were in compliance.
- ❑ The Department received 487 complaints of violations of the "no smoking in bars" law in 1999.

Tobacco

Response

YOUTH AND TOBACCO

- The Department provided funding, training, and technical assistance to nine youth community capacity building projects. Youth conducted action research and based on their findings, successfully advocated for:
 - Enforcement of law requiring warning labels on bidis (Indian cigarettes) popular among San Francisco youth.
 - Enforcement of ban on importation of bidis produced with indentured child labor in India.
 - Passage of school board policy banning purchase of tobacco subsidiary products.
- Active enforcement of illegal tobacco sales to minors by the Police Department and the local ordinance banning outdoor tobacco ads by the Department of Consumer Protection.

TOBACCO EDUCATION

- Using messages developed through focus groups, the Department developed Cable TV ads encouraging smoking parents to smoke outdoors to protect their children from environmental tobacco smoke.
- During 1999, 155 smokers enrolled in the Department's Stop Smoking classes. Among participants who completed both pre-tests and post-tests, 55% quit.

SMOKE FREE BAR LAW

- In response to complaints, 13 bar owners and 71 patrons were cited for illegal smoking in bars.
- Educational letters were sent to bar owners following complaints informing them of their duties and legal liabilities.

Mental Health

- ❑ Between FY 1992–1993 and FY 1998–1999, the number of clients served in Community Mental Health Services increased from 16,255 to 21,212.
- ❑ Approximately 8,000 (40%) of CMHS clients are uninsured.¹
- ❑ People with psychiatric disabilities make up more than half of the City's unsheltered homeless population, but only 5% to 15% of the shelter population.²
- ❑ Involuntary hospitalization rates have been higher in San Francisco than in all other counties by a substantial margin.²

¹ San Francisco, Mental Health Board Annual Report, April 1999.

² San Francisco Department of Public Health, Division of Mental Health Supported Housing Plan, 1995-2000.

Mental Health Response

INCREASE IN CASE MANAGEMENT AND OUTPATIENT SERVICES

- In FY 1998–1999:
 - Community Mental Health Services (CMHS) case management services increased by 7%.
 - Outpatient and case management programs were able to reduce their client's hospital days by 26%.
- In CMHS Children's Services, eight new programs were developed with Medi-Cal funding to serve approximately 300 new under-served clients in FY 1999–2000.
- In FY 1998–1999, CMHS increased homeless outreach by redirecting two positions to the Mobile Support and Treatment Team to add capacity and provide services in the Bayview District.
- In FY 1999–2000, CMHS increased funding to providers for outreach services targeted at homeless individuals, and limited and non-English speaking populations in non-traditional settings.

SAN FRANCISCO MENTAL HEALTH PLAN

Development

- Over the past five years, CMHS has developed the San Francisco Mental Health Plan (SFMHP). SFMHP provides specialized mental health services and is regulated by the State of California.
- SFMHP is the safety net foundation for San Franciscans who are at risk for mental illness and who are without adequate insurance or financial support.

Administrative Changes

- Formation of the SFMHP involved reshaping the delivery of community mental health services by:

Mental Health Response

SAN FRANCISCO MENTAL HEALTH PLAN

Administrative Changes (Continued)

- Integrating private providers (clinicians, psychiatrists and group practices) with the public clinic based system to form the System of Care,
- Creating a centralized toll-free line for making treatment referrals,
- Reshaping priorities to focus more broadly on the mental health needs of all San Franciscans rather than just the seriously mentally ill.

SFMHP Goals

- ❑ Increase access to outpatient mental health services for San Francisco Medical beneficiaries and uninsured residents.
- ❑ Reduce unnecessary institutionalization and costs by assuring availability of adequate community alternatives.

SUPPORT OF COMMUNITY SYSTEM OF CARE

- ❑ In FY 1999–2000, CMHS is adding 23 residential care beds and an acute diversion residential treatment program.
- ❑ In FY 1999–2000, CMHS increased its intensive in-home “wrap-around” services to foster care children over 3 years of age.

IMPROVED ACCESS TO MEDICATIONS

- ❑ In April of 2000, CMHS will introduce a new pharmacy benefits program, to improve its ability to manage pharmaceutical benefits and assure that uninsured consumers have access to the medications they need.

San Francisco's Uninsured

- ❑ California's uninsured population increased by 276,000 in 1998 to 7.3 million.¹
- ❑ Of those 7.3 million uninsured, 6 million are in working families.¹
- ❑ As of November 1999, 1.48 million uninsured children in California were eligible for Medi-Cal or the Healthy Families Program, but were not enrolled.¹
 - Based on March 1998 and 1999 Current Population Surveys it is estimated that 10% of uninsured children eligible for Medi-Cal or the Healthy Families Program live in the Greater Bay Area Region encompassing San Francisco County. ¹
- ❑ An estimated 130,000 San Franciscans are uninsured.²

¹ HH Schauffler and ER Brown. The State of Health Insurance in California, 1999. Berkeley, CA: Regents of the University of California, January 2000.

² Mayor's Blue Ribbon Committee on Universal Health Care, Achieving Health Insurance for San Francisco's Uninsured, May 1998.

San Francisco's Uninsured

SAN FRANCISCO'S EFFORTS TO EXPAND HEALTH COVERAGE

San Francisco remains committed to expanding health care coverage to uninsured and has taken the following incremental steps:

□ MAYOR'S BLUE RIBBON COMMITTEE ON UNIVERSAL HEALTH CARE

- As a part of the Mayor's proposal to expand coverage the Department administered a survey among San Francisco small businesses.
- The objectives of the survey were to: 1) characterize the current rates at which small San Francisco firms offer, and employees of small firms accept, employer-sponsored health insurance coverage, and 2) estimate the rates of employer and employee participation in a proposed San Francisco purchasing alliance program.

□ HEALTHY WORKERS

- The Department, in conjunction with, the Department of Human Services, the In-Home Supportive Services Authority and Local 250 implemented a program to provide health care coverage for approximately 4,500 in-home support services workers.

□ SAN FRANCISCO CHILD CARE PROVIDERS HEALTH CARE BENEFITS PILOT

- In FY 1999–2000 the Mayor committed \$250,000 to launch a pilot program to increase access to health insurance for child care providers.
- The pilot program provides a subsidy for eligible family child care providers in the first phase of the program and expands subsidies to eligible child care centers in the second phase. The program will create a child care provider purchasing pool for health care.
- The Mayor's Department of Children, Youth and Their Families is implementing this pilot program through a contract with the San Francisco Health Plan.

San Francisco's Uninsured

❑ **MEDI-CAL COVERAGE**

- In collaboration with the Department of Human Services and the Bringing Up Healthy Kids Coalition, the Department is supporting efforts to broaden outreach and enrollment in the Medi-Cal program. Medi-Cal provides no or low-cost health care coverage to certain low-income families.

❑ **HEALTHY FAMILIES EXPANSION**

- The Department and other community advocates continue to work on expanding enrollment in California's Healthy Families Program (HFP) which provides health, dental and vision care coverage to uninsured children.
- San Francisco's current enrollment in HFP is 7,313.
- Currently, there are over 38 entities certified to enroll children into the Healthy Families Program. The Department's Community Health Network is certified to train its eligibility workers about the program.

❑ **SAN FRANCISCO BRINGING UP HEALTHY KIDS COALITION (BUHK)**

- The Department is a participant in this Coalition which advocates and promotes health care coverage to uninsured children and families.
- Currently, the Coalition is working with San Francisco Unified School District on a strategy to determine if participating children in free or reduced-price school meal programs are eligible for Medi-Cal, Healthy Families, Kaiser Cares for Kids or other no or low cost health insurance.

HIV/AIDS

- ❑ San Francisco's rate of reported AIDS cases of 103.51 cases per 100,000 population (for the time period of 1996–1998) is well above the Year 2000 Objective case rate of 43.00.¹
- ❑ In San Francisco the majority of reported AIDS cases continues to be among men who sex with men and injection drug users.
- ❑ Between 1990 and 1999,* AIDS cases declined 80.1% in all transmission categories. However, in some ethnic groups the decline in AIDS cases was less (see page 29 of Appendix A):
- ❑ 6% or 506 of living AIDS cases are women.²
- ❑ Of the 8,598 living AIDS cases in San Francisco:
 - 68% or 5,889 cases are among Whites,
 - 15% or 1259 cases are among African Americans,
 - 13% or 1097 cases are among Latinos,
 - 4% or 305 cases are among Asian/Pacific Islanders and
 - <1% or 48 cases are among Native Americans.²

*Cases reported may not be complete in later years. Cases reported by year of diagnosis.

¹ California Department of Health Services, County Health Status Profiles, April 2000.

² Quarterly AIDS Surveillance Report, San Francisco Department of Public Health, AIDS Cases Reported through March 2000, (April, 2000).

HIV/AIDS

Response

COMMUNITY BASED PROVIDER NETWORK

- The goal of the community based provider network is to reduce the number of new HIV infections by targeting populations who may not have access to stand-alone HIV services, but who may have access to other public health services.

TARGETING HIV PREVENTION SERVICES

- Continue to target communities with the largest number of AIDS cases:
 - Men who have sex with Men (MSM)
 - MSM Injection Drug Users (IDUs)

But also increase services to emerging populations such as women.

PREVENTION FOR POSITIVES PROGRAM

- A new prevention project was developed to improve HIV positive individuals ability to access a system of health care and social support services.

SUPPORTING OUTREACH THROUGH COMMUNITY PLANNING

- HIV Prevention Section will be evaluating community planning efforts to ensure outreach to and input from at-risk and impacted communities.
- The community planning process is facilitating community members input into design, evaluation and accountability of programs and services.

Health Promotion and Prevention

- ❑ Improved health outcomes are possible when prevention strategies take into account social and cultural and contexts.
- ❑ Injury epidemiology is leading to a growing awareness that specific types of injuries in specific populations are predictable and preventable.
- ❑ San Francisco's crude death rate from unintentional injuries was 38.0 per 100,000 population, above both the California crude death rate and the Year 2000 National Objective for the time period 1996–1998.¹
- ❑ Tobacco is the leading preventable cause of death in the United States. Environmental interventions to reduce tobacco use including regulatory changes, media campaigns, and community capacity building have been successful.

¹ California Department of Health Services, County Health Status Profiles, April 2000.

Health Promotion and Prevention Response

NUTRITION PROMOTION

- Women, Infants and Children (WIC) has a special project to encourage good nutrition through reading to children. KQED TV supports this project by providing children's books with nutritional messages in English, Spanish, and Chinese.
- The Nutrition Network Project, administered by the Children, Youth and Families Section, targets San Francisco's under-served populations to promote healthy eating and physically active lifestyles. The project uses social marketing techniques to reach a large number of people.

INJURY PREVENTION

- A public education campaign, *Stop Red Light Running*, was sponsored to decrease San Francisco's high rate of motor vehicle collisions caused by drivers running redlights and injuring 1,400 persons each year.
- The CHDP Health Education KIDS Plate Helmet Project provided 620 helmets to low income children ages 5-12. The project encouraged proper helmet use and instructions about safe bicycling, skate boarding and roller blading. The project is a collaborative effort between Blue Cross, The San Francisco Health Plan, and the Department.

TOBACCO POLICY ADVOCACY

- The Department supported Booker T. Washington Community Service Center's investigation of the use of bidis (Indian cigarettes) among youth as well as their availability in stores and illegal sales rate. This community capacity building process consisted of filing a complaint with the Federal Trade Commission which resulted in mandated warning labels on bidis packages.

Communicable Diseases

- ❑ San Francisco's tuberculosis case rate of 26.61 per 100,000 population is well above the Year 2000 National Objective of 3.50 for the time period 1996–1998.¹
- ❑ Tuberculosis disproportionately affects immigrants, the homeless and persons with AIDS.
- ❑ San Francisco's crude case rate of reported primary and secondary syphilis cases at 4.93 per 100,000 population is above the Year 2000 National Objective crude case rate of 4.00 for the time period of 1996–1998.¹
- ❑ Rates for gonorrhea, chlamydia, and syphilis within the adolescent population increased 15% between 1998–1999 (see page 30 of Appendix A).

¹ California Department of Health Services, County Health Status Profiles, 2000.

Communicable Diseases

Response

TUBERCULOSIS CONTROL GUIDELINES

- The Tuberculosis Control Section in conjunction with the American Lung Association and the San Francisco TB Task Force developed TB control guidelines which were adopted by San Francisco homeless shelters as community standards.
- The Department is developing TB control guidelines for single-room-occupancy (SRO) hotels in high incidence TB areas.

SYPHILIS OUTBREAK MANAGEMENT

- The Department identified a cluster of early syphilis among gay men who met the majority of their sexual partners in a chat room on the Internet.
- The Department worked closely with Planet Out, the largest gay Internet community in the world, to educate and inform users of the syphilis outbreak and to urge them to get tested. The Department's approach to this incidence is being used nationally as a model for other STD programs.

EXPANDING STD SCREENING

- STD Services worked with the San Francisco Unified School District to make STD screening and free condoms available to students in the public high schools.
- During this fiscal year 664 youth were screened for STDs and 16 new infections were identified and treated.
- The STD Program operates the largest jail STD screening project in the United States. This fiscal year the jail STD screening project provided treatment for nearly 90% of persons identified in the jails with an STD.

EXPANDED STD TREATMENT

- In collaboration with COYOTE and the Exotic Dancers Alliance, the STD Program has established the St. James Infirmary, which provides free, confidential non-judgmental medical and social services to sex workers.

Communicable Diseases

Response

EXPANDED STD TREATMENT (CONTINUED)

- ☐ STD Services implemented single dose therapy for gonorrhea and chlamydia to make treatment for these infections as simple as possible.
- ☐ STD Services program implemented a program whereby patients are given preventive therapy for their sexual partners who are unlikely to come in for clinic based evaluation and treatment.
- ☐ The STD Program is one of two sites in San Francisco which offers HIV post-exposure prevention services to individuals who have been exposed to HIV.

Environmental Health

- ❑ Analysis of zip code level hospitalization data indicates asthma is not uniformly distributed geographically among San Francisco residents.
- ❑ New environmental health issues include indoor air quality and its relationship to asthma and emerging pathogens and chemical contaminants in municipal water.
- ❑ The amount of solid waste produced in San Francisco continues to increase. The City's recycling efforts are effective and improving, but still fall short of the state-mandated goal of 50% of total solid wastes.
- ❑ The public health definition of key environmental determinants has broadened to recognize community and social contexts. Public health goals now include preventing deterioration of neighborhood infrastructure, countering targeted media promotion of behaviors (e.g., cigarette smoking), restricting residential alcohol outlet density, expanding access to good nutrition, increasing access to open space and encouraging social cohesion.

Environmental Health Response

ASSESSING HOME LIVING CONDITIONS

- The Department initiated collaboration with adult asthma care physicians at San Francisco General Hospital to provide environmental assessments of the homes of patients with asthma to identify and eliminate suspected environmental triggers.

SOLID WASTE CLEANUP

- The Department monitored and oversaw, the cleanup and removal of over 3,000 cubic yards of solid waste illegally disposed on a vacant lot in the Bayview-Hunters Point District. The Department and the City Attorney's Office pursued legal action against the illegal solid waste operator resulting in the closure of the illegal business.

ADDRESSING ENVIRONMENTAL ISSUES WITH THE COMMUNITY

- The Environmental Health Section is working to collaborate with communities and other City agencies to improve health outcomes associated with environmental risk factors:
 - Staff have attended neighborhood meetings in the Richmond, the Mission, Chinatown, Fisherman's Wharf, the Tenderloin and Bayview Hunters Point (BVHP) to better understand community environmental concerns.
 - A quality of life team consisting of personnel from the Department, the Port, San Francisco Police Department and Department of Public Works randomly conduct visits at Fisherman's Wharf for educational and inspection purposes.
 - Environmental Health continues to participate and support the Bayview Hunters Point Health and Environmental Resource Center in its effort to decrease alcohol sales in this neighborhood.

Children, Youth, and Families

- ❑ San Francisco's adolescent birth rate to (mothers aged 15 to 19) of 33.3 per 1,000 females is low compared to the State average of 57.2 for the time period 1996–1998. However, African–American and Hispanic adolescents account for a disproportionate share of births to adolescent mothers compared to the distribution of all births in San Francisco by race and ethnicity (see page 40 of Appendix A).¹
- ❑ From January 1998 through September 1999, 1,768 child care slots were created in family day care homes and child care centers.²
 - There is an increased need for access to health services in child care centers.

¹ California Department of Health Services, County Health Status Profiles, April 2000.

² San Francisco Child Care Planning and Advisory Council: Needs Assessment and Data Analysis, January 2000.

Children, Youth, and Families

Response

TEEN PREGNANCY

- In conjunction with Children, Youth and Family Services, Maxine Hall Health Center launched the Teen Smart Program to tackle the high teen pregnancy rate among African American teens in the City's Western Addition
 - Provides comprehensive primary care and sexual health-related services through a team approach involving community outreach.

HEALTH AND SAFETY FOR CHILDREN IN CHILDCARE

- To improve health and safety outcomes for children in childcare, the Childcare Health Project has hired public health nurses to provide health and safety consultation at four designated childcare centers in targeted San Francisco neighborhoods.

ENHANCED HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

- California has approved a new program, *Health Care for Children in Foster Care*. New funding will allow more public health nursing services to meet the health care needs of children in foster care.
- The CHDP Foster Care Unit has been expanded to include services that are designed to improve the health status of high-risk children.
- Currently, there are 14 public health nurses who provide crucial services to approximately 3,000 kids in the Child Welfare Foster Care system.

CHILD ABUSE PREVENTION

- The *Sistah Sistah* home visiting program was expanded to target more women. This child abuse prevention program now serves Hispanic women in their last trimester residing in Visitacion Valley (zip code 94134), in addition to, African American women residing in this zip code.

Overview of Department of Public Health Strategic Planning Initiative

Overview of Strategic Planning

DEFINITION

- ❑ A formal ongoing process of developing, evaluating, and implementing goals to guide actions and decision making by organizations.

OVERARCHING GOAL

- ❑ Better match an organization's resources and capabilities to the external environment faced by the organization.

PURPOSES OF STRATEGIC PLANNING

- ❑ Re-evaluate how the Department meets its two fundamental public health roles:
 - (1) as the government entity responsible for carrying out population-based health activities and
 - (2) as a provider of health care services.
- ❑ Improve the Department's ability to develop a clear strategy for fulfilling its mission and vision statements.
- ❑ Help the Department prioritize health concerns in collaboration with the community.

What are the Strategic Planning Goals?

- ☐ respond to San Francisco's changing demographics and health needs,
- ☐ plan with the community for health improvement,
- ☐ strengthen prevention efforts,
- ☐ identify populations the Department should serve,
- ☐ develop program priorities to maximize the effectiveness of limited resources and
- ☐ respond to funding trends.

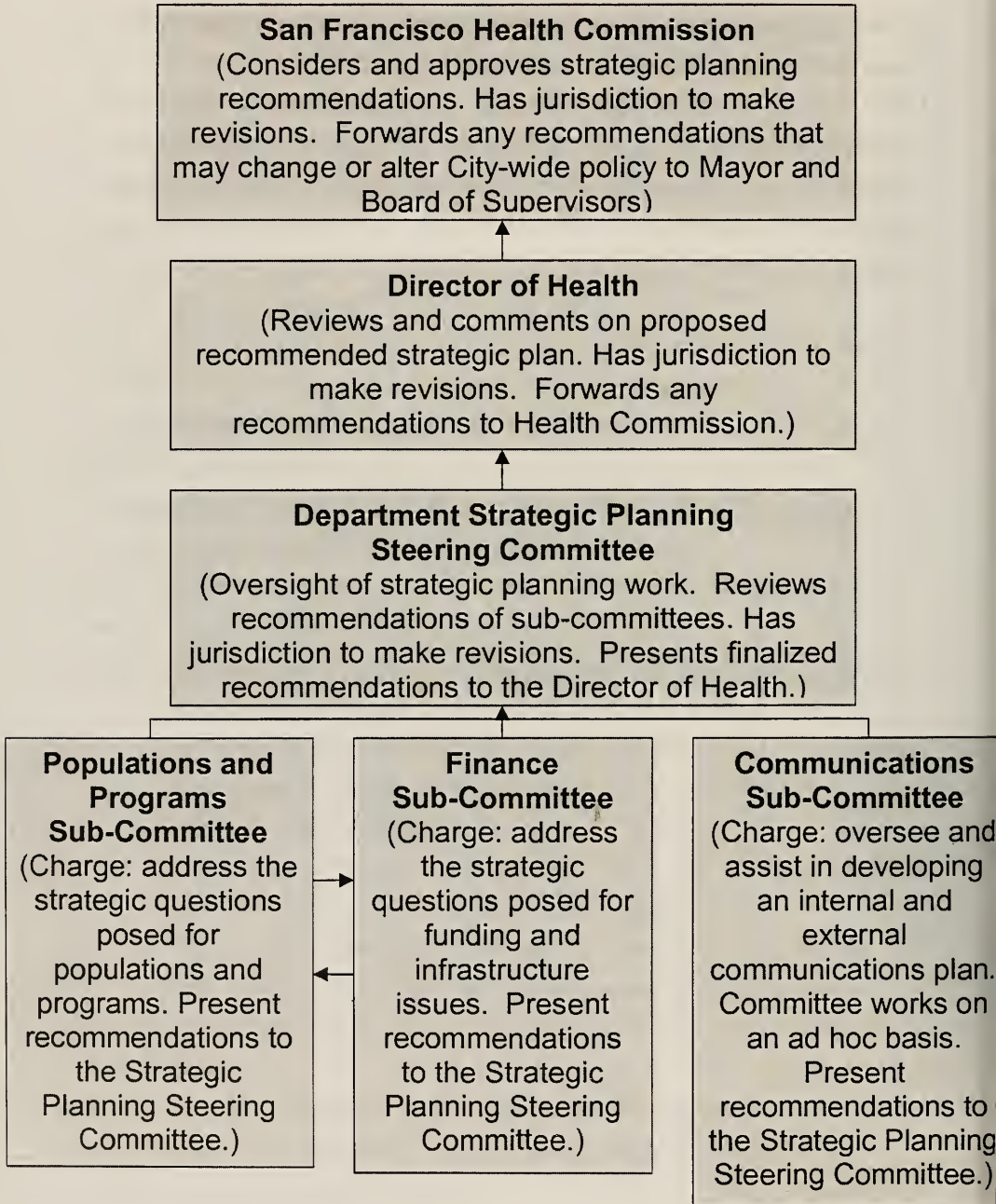
Guiding Principles

- ❑ Ensure that the Department develops a clear strategy for fulfilling its mission and vision statements and clearly articulates its role in the delivery of services to San Franciscans.
- ❑ Take a broad view of health given that there are many social determinants that impact the community's health—e.g., income, education, housing.
- ❑ Continue to support the Department's roles in overseeing public's health and delivering health care services.
- ❑ Use health data (quantitative and qualitative), community needs, health mandates and program evaluation to guide the development of the Department's services.
- ❑ Ensure that health services are comprehensive (including a continuum of care) and integrated to effectively address the health problems of communities and individuals.
- ❑ Emphasize the expansion of primary prevention activities to reduce preventable illness and injury.
- ❑ Emphasize improving service integration at the following levels:
 1. integration of Population Health and Prevention and Community Health Network services within the Department,
 2. integration of Department services with community resources and providers,
 3. integration of Department services with the services of other City departments for the same populations and
 4. integration of program contracting functions to improve contracting efficiency for the contractor and Department.
- ❑ Emphasize blending revenues where possible to support service integration.
- ❑ Recommend strategies for the Department's legislative advocacy to improve San Francisco's health status and the Department's ability to address health issues.

Guiding Principles

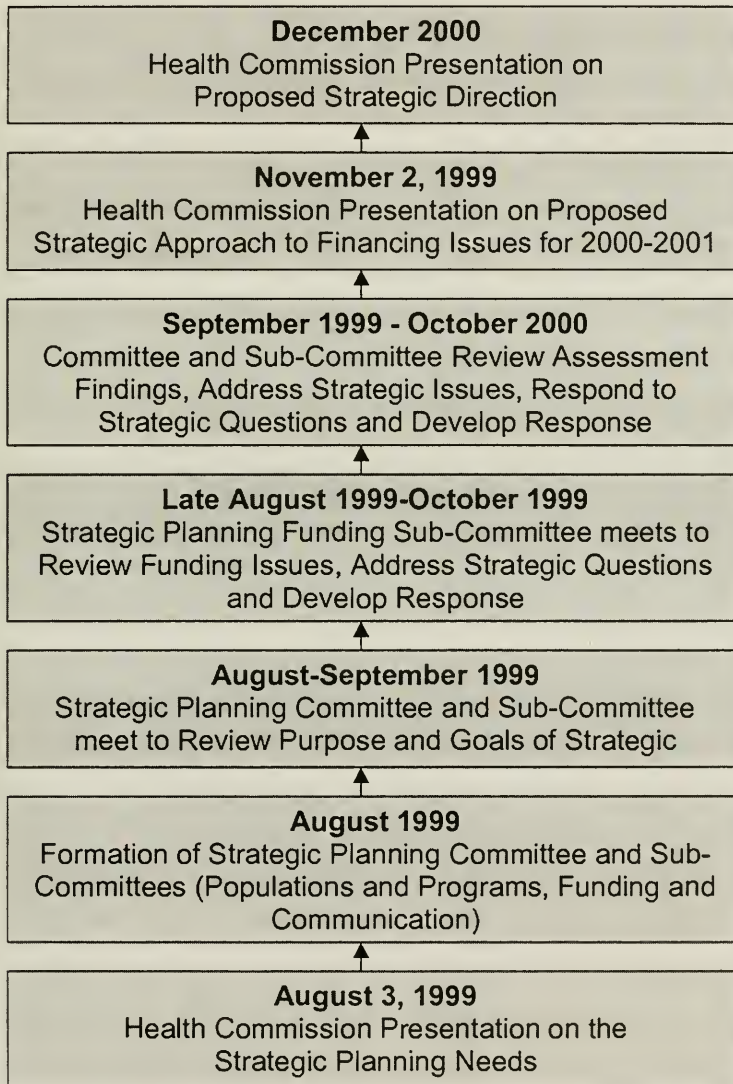
- ❑ Develop a strategic vision for the Department that recognizes current fiscal realities but is not driven by them.
- ❑ The overall health of San Francisco is a community-wide responsibility requiring combined and integrated resources—including public health, other providers, health advocates and community agencies.

Committee Structure and Process



Proposed Strategic Planning Timeline

August 1999 – December 2000



Stakeholder Involvement in Strategic Planning

STAKEHOLDER REPRESENTATION

- ❑ Members of the strategic planning committees represent a diversity of stakeholders including:
 - community providers
 - health advocates
 - businesses
 - consumers
 - staff
 - community based organizations

COMMUNITY MEETINGS

- ❑ The Department will hold town hall meetings for both the public and staff at three critical junctures of the process:
 - before recommendations are developed,
 - while recommendations are being drafted and considered and
 - after the draft strategic plan has been completed.
- ❑ Over the course of the strategic planning initiative culturally competent town hall meetings will be held in all supervisorial districts to gather input into the strategic plan.
- ❑ The Department is gathering further input into the strategic plan by attending existing community advisory board and neighborhood meetings.

EASY ACCESS TO INFORMATION

- ❑ Community can obtain information through a direct line to designated Department staff.
- ❑ Web Site dedicated to the Department's strategic planning initiative.

Appendix A

OVERVIEW OF HEALTH STATUS

Public Health Week April 3 – 9, 2000



Population Health and Prevention Division
San Francisco Department of Public Health
www.dph.sf.ca.us

Who we are

How we Live

Our health

Who we are

How we live

Our health

Who we are

How we live

Our health

Who we are

How we Live

Our health

Who we are

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Introduction

**Who we are
How we live
Our health**

For Public Health Week, April 3 – 9, 2000, the Department of Public Health presents this annual overview of the health of San Franciscans. Each year we work to improve this report by adding data and information to enhance our understanding of the health of our community. Because social conditions and personal health behaviors have a significant effect on health, this year's report has been expanded to include additional statistics on social issues such as poverty and unemployment, behaviors such as exercise (physical inactivity and overweight), and health risks such as high blood pressure.

Assessment is a core function of the San Francisco Department of Public Health. It is an ongoing activity that provides us with useful information. The data used to develop this report comes from our best available sources including surveillance data, census/demographic data, program utilization or diagnosis data, vital records and surveys. In some cases, our data are limited. We are working to expand our information base as we strive to create a more complete picture of the health of San Franciscans.

We are pleased to present you with this report and hope that it will contribute to a better understanding of **who we are, how we live, and our health**.

The report was produced by the Planning and Community Health Epidemiology and Disease Control sections of the Population Health and Prevention Division of DPH

Additional copies of this report can be downloaded from our web page at www.dph.sf.ca.us or by calling:

(415) 255-3470
Planning Office
Population Health and Prevention
San Francisco Department of Public Health

San Francisco

Who
we
are

Who we are

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Who We Are

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How we live

Our health

Who we are refers to the characteristics of the population of San Francisco.

These characteristics play an important role in determining our health status.

San Francisco's cultural diversity results in a wide array of health beliefs and practices. It is important that our health and social service systems provide culturally and linguistically appropriate services to this diverse population. The age of our population is also an important factor in our health status because health problems and needs generally increase as we age.

Demographics

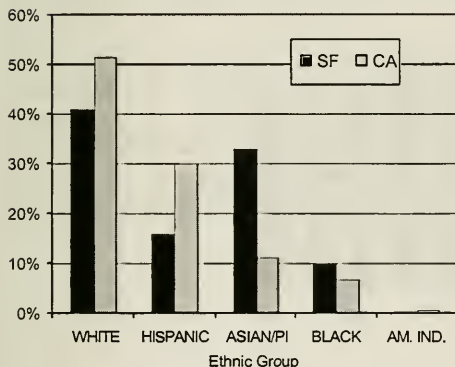
Who we are

POPULATION

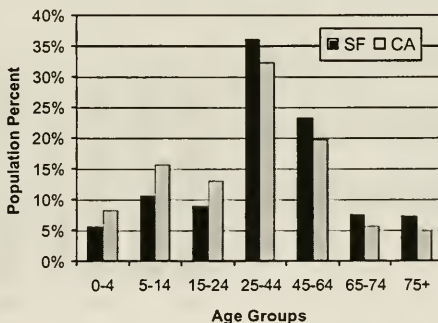
Over the last eight years, San Francisco's total population grew from 723,900 in 1990 to 784,600 in 1998, an 8.4% increase. When compared to the rest of California, San Francisco's population has a smaller proportion of children and youth under age twenty-five and a greater number of adult and senior citizens. San Francisco's unique demographic profile includes a substantially larger proportion of Asian and Pacific

Islanders, and smaller proportions of Hispanics than California as a whole. Among ethnic groups within San Francisco, whites demonstrate the lowest proportion of very young children ages 0-4 as well as the greatest proportion of middle-aged adults between the ages of 45 – 65 years old. The Hispanic population has the largest proportion of young children and the smallest number of seniors over 75 years old.

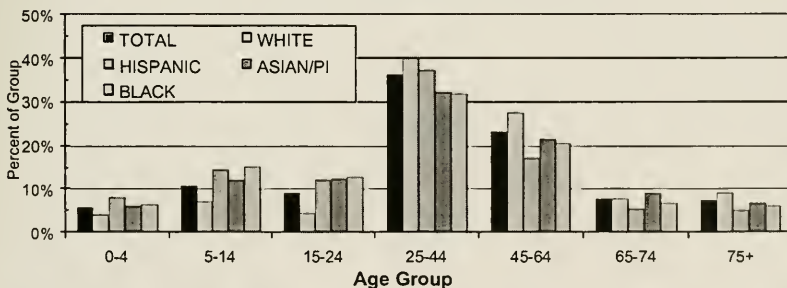
Population by Major Ethnic Group



Population by Age Group



Age Distribution by Ethnicity



Source: Ca. Dept. of Finance, *Race/Ethnic Population Estimates with Age and Sex Detail, 1970 – 2040*. Sacramento, CA, December 1998.

Demographics

Who we are

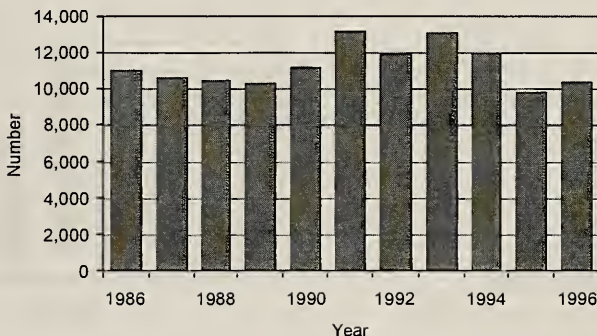
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IMMIGRATION

San Francisco continues to attract many immigrants from other countries. The immigration data below reflect those people admitted for permanent residence in the U.S. via San Francisco. An unknown

number of these people actually settle elsewhere, while others admitted elsewhere settle here. It has recently been estimated that for California as a whole, 18.8% of its 1996 population were non-citizens of the U.S.

***Documented Immigrants Admitted to
San Francisco, 1986 - 1996***



Sources: Urban Institute, Assessing the New Federalism, State Reports and Highlights, Table 1, errata (website) and United States Immigration and Naturalization Service, FedStats, <http://www.fedstats.gov/cgi-bin/mapstats/INSLookup?06075>

Social Security

Who we are

Social Security, the Federal retirement insurance program, provided income support to almost one in seven San Franciscans in December 1998, 105,000 people in all. The data in the table below show how many people received benefits in

the main eligibility categories of retirement, survivorship, or disability. The average monthly benefit, shown in the last line for December 1997, falls far below the amount needed to support even a modest level of independent living in San Francisco.

San Francisco Social Security Recipients, 1998

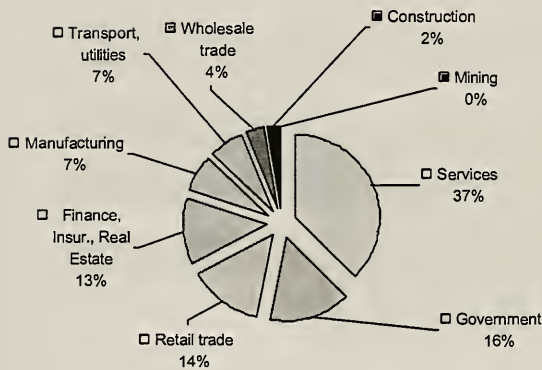
Social Security	Retirement Benefits				Survivor Benefits		Disability Benefits			Aged 65 or older	
State or County	Total	Retired workers	Wives & husbands	Children	Widows & widowers	Children	Disabled workers	Wives & husbands	Children	Men	Women
CA	4,050,885	2,592,286	290,078	46,380	431,486	171,921	404,574	14,230	109,950	1,282,189	1,741,974
SF	105,155	70,850	5,760	1,250	9,990	2,765	12,900	175	1,465	32,975	47,335
SF % of CA	2.6%	2.7%	2.0%	2.7%	2.3%	1.6%	3.2%	1.2%	1.3%	2.6%	2.7%
Benefits/beneficiary (Dec. '97)											
SF	\$ 716.94	\$ 765.91	\$ 881.18	\$ 334.41	\$ 735.01	\$ 511.47	\$ 734.30	\$ 177.78	\$ 221.09	\$ 828.22	\$ 693.09

Source: Social Security Administration, SSI Recipients by State and County, December 1998, Table 3
http://www.ssa.gov/policy/pubs/pubs_pages/pubs_programDataByGeographic.htm

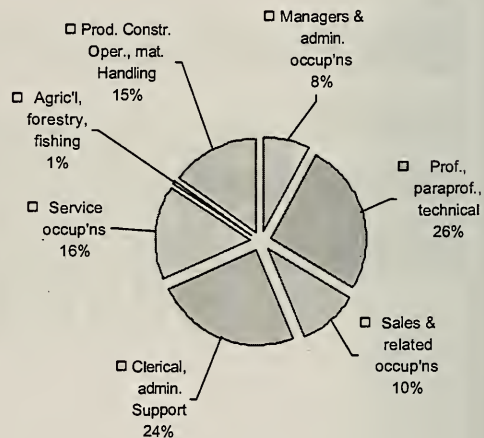
San Francisco provided an estimated 539,600 jobs in 1999. As the figures below show, a high proportion of these jobs are concentrated in the service industry and government, with a high proportion of professional, technical and support

occupations. The number of jobs far exceeds the size of San Francisco's resident labor force of an estimated 422,000, reflecting the fact that many people who do not live in San Francisco commute here to work.

**Employment by Industry,
San Francisco, 1999**



**San Francisco Employment by
Major Occupational Group, 1999**



Source: California Employment Development Department, Labor Market Information Division

San Francisco

How

we

live

How we live
How we Live
How we live
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How We Live

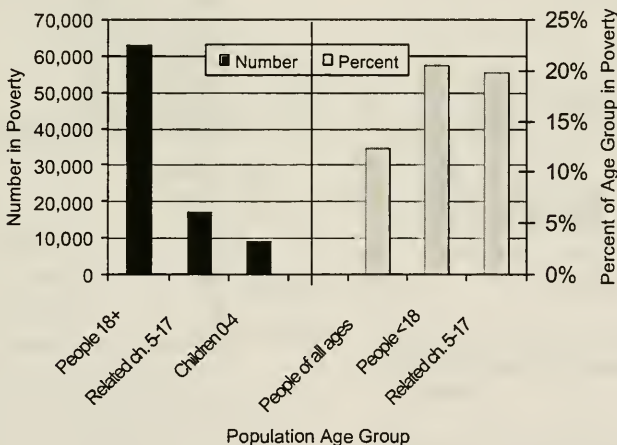
Who we are
How we live
Our health

How we live determines much about how long we live and how healthy we are – what health-influencing conditions we are exposed to, and what personal and community resources are available to us. The environments that surround us at home, on the streets, in our neighborhoods, in school, and at work, all can influence our health. So do our activities and habits, and our access to financial, social, health care, and other essential resources. Most disease and injury experienced by San Franciscans could be prevented or postponed by changes in how we live.

Compared to higher-income populations, groups living in poverty have higher mortality from many causes, report themselves to be less healthy, are less likely to have regular sources of health care, and seek health attention less often. Since Federal poverty levels are set for the nation by a formula which greatly underestimates the real costs needed for subsistence-level

living in San Francisco, the Federal poverty estimates for 1995 shown in the figure below, likely underestimate the size of the population living in poverty here.

**San Francisco Poverty
Population by Age, 1995**



Source: United States Bureau of the Census, Small Area Income and Poverty Estimates Program, released February, 1999.

Poverty

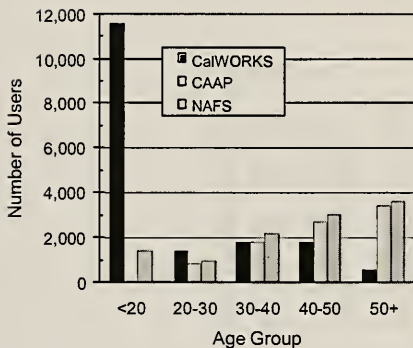
How we live

PUBLIC ASSISTANCE

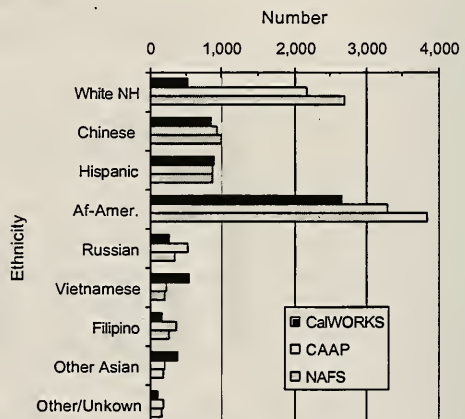
Demographics of public assistance users provides a reflection of the distribution of San Francisco's low income population, although program eligibility restrictions, time limits, and differential use by population

groups influences the picture of participants shown by the data below.

Public Assistance Users by Age



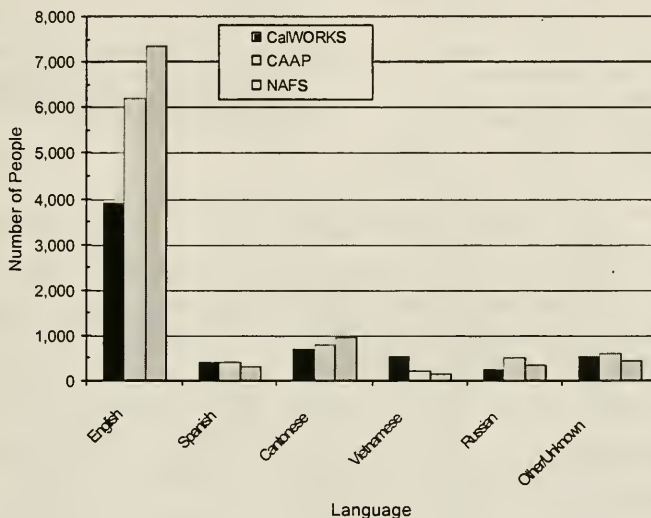
Public Assistance Users by Ethnicity



Sources: SF Department of Human Services, January 2000, CalWORKS SnapShot Quarterly Report
 SF Department of Human Services, December 1999, CAAP SnapShot Quarterly Report
 SF Department of Human Services, December 1999, NAFS SnapShot Quarterly Report

PUBLIC ASSISTANCE—CONT.

Public Assistance Users by Language



The three main benefit programs shown are:

- CalWORKs, serving families with children (the descendent of AFDC, since changed by the 1996 welfare reform to the federal TANF program, Temporary Assistance to Needy Families);
- CAAP (formerly GA, General Assistance, for needy adults not supporting children); and
- Food Stamps, the Federal program most widely available to low-income persons. NAFS refers to Non-Assistance Food Stamps, the part of the

program for people not automatically eligible through enrollment in other programs.

These are "snapshot" data, showing enrollment at a point in time. They are from the SF Dept. of Human Services' most recent quarterly reports for each program, December 1999 for NAFS and CAAP, and January 2000 for CalWORKS. For CalWORKS recipients under age 20, 145 were caregivers rather than dependent children.

Sources: SF Department of Human Services, January 2000, CalWORKs SnapShot Quarterly Report
 SF Department of Human Services, December 1999, CAAP SnapShot Quarterly Report
 SF Department of Human Services, December 1999, NAFS SnapShot Quarterly Report

Cost of Living

How we are
How we live
Our needs

San Francisco is an expensive place to live, especially for housing. A recent study estimated the minimum cost needed for families with two children to be able to live comfortably in each region and for California overall. San Francisco is part of Region IV, which includes Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara counties. The results for this region are shown below, along with

comparisons of the minimum comfortable cost of living (COL) to San Francisco's median household income and to income levels provided by several standards used for low-income families. The income needed in the Bay Area is about 20% greater than that needed for the whole State, and all the low income standards fall well below the minimum income level needed to live comfortably in the Bay Area.

Bay Area Minimum Comfortable Cost-of-Living (COL) Comparisons

BAY AREA (REGION IV) (San Francisco, Alameda, Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara)			
Expenses (1st row = monthly expenses; 2d row = expense as % of Minimum COL)			
Expense	Family		
	Single parent	Two Parents (One Working)	Two Working Parents
Housing/Utilities	\$ 827 22.5%	\$ 1,035 34.0%	\$ 1,035 23.1%
Child Care	\$ 1,106 30.0%	\$ - 0.0%	\$ 1,106 24.7%
Transportation	\$ 244 6.6%	\$ 244 8.0%	\$ 244 5.4%
Food	\$ 382 10.4%	\$ 583 19.2%	\$ 583 13.0%
Health Care	\$ 255 6.9%	\$ 390 12.8%	\$ 390 8.7%
Miscellaneous	\$ 311 8.4%	\$ 379 12.5%	\$ 379 8.5%
Taxes	\$ 556 15.1%	\$ 412 13.5%	\$ 741 16.5%
Monthly Total	\$ 3,681 100.0%	\$ 3,043 100.0%	\$ 4,478 100.0%
Annual Total	\$ 44,172	\$ 36,516	\$ 53,736
Basic family wage (Hourly)	\$ 21.24	\$ 17.56	\$ 12.92

Source: California Budget Project, *Making Ends Meet: How Much does It Cost to Raise a Family in California?* Sacramento, October 1999

Cost of Living

How we live

COST OF LIVING—CONT.

California Minimum comfortable Cost-of-Living (COL) Comparisons

CALIFORNIA				
Expenses (1st row = monthly expenses; 2Nd row = expense as % of <i>Minimum COL</i>)				Region IV as % of California Statewide Costs
Expense	Family			
	Single parent	Two Parents (One Working)	Two Working Parents	
Housing/Utilities	\$ 608	\$ 762	\$ 762	136%
	19.8%	29.2%	20.4%	
Child Care	\$ 926	\$ -	\$ 926	119%
	30.2%	0.0%	24.8%	
Transportation	\$ 244	\$ 244	\$ 244	100%
	8.0%	9.3%	6.5%	
Food	\$ 382	\$ 583	\$ 583	100%
	12.4%	22.3%	15.6%	
Health Care	\$ 216	\$ 330	\$ 330	118%
	7.0%	12.6%	8.8%	
Miscellaneous	\$ 311	\$ 379	\$ 379	100%
	10.1%	14.5%	10.1%	
Taxes	\$ 382	\$ 315	\$ 516	146%
	12.4%	12.1%	13.8%	
Monthly Total	\$ 3,069	\$ 2,613	\$ 3,740	120%
	100.0%	100.0%	100.0%	
Annual Total	\$ 36,828	\$ 31,356	\$ 44,880	120%
Basic family wage (Hourly)	\$ 17.71	\$ 15.08	\$ 10.79	

Source: California Budget Project, *Making Ends Meet: How Much does It Cost to Raise a Family in California?* Sacramento, October 1999

Cost of Living

How we live

COST OF LIVING—CONT.

Earning Level Comparisons

Earnings Level Comparisons:

How do various income standards compare to the minimum comfortable cost-of-living level?

Income Standard	Bay Area Annual Income			California Annual Income			Hourly Wage
	Single Parent	Two Parents (one working)	Two Working Parents	Single Parent	Two Parents (one working)	Two Working Parents	
Federal Poverty Level (FPL)	\$ 13,880	\$ 16,700	\$ 16,700	\$ 13,880	\$ 16,700	\$ 16,700	Fam 1: \$6.67
Min. COL as % of FPL	318%	219%	322%	265%	188%	269%	Fam 2: \$8.03
FPL as % of COL	31%	46%	31%	38%	53%	37%	Fam. 3: \$4.01
CA Minimum Wage	\$ 11,960	\$ 11,960	\$ 23,920	\$ 11,960	\$ 11,960	\$ 23,920	\$5.75
Min. Wage as % of COL	27%	33%	45%	32%	38%	53%	
Living wage	\$ 22,880	\$ 22,880	\$ 45,760	\$ 22,880	\$ 22,880	\$ 45,760	\$11.00
Living wage as % of COL	52%	63%	85%	62%	73%	102%	
Low Income	\$ 30,000	\$ 30,000	\$ 30,000	\$ 30,000	\$ 30,000	\$ 30,000	Fam. 1,2: \$14.42
Low income as % of COL	68%	82%	56%	81%	96%	67%	Fam. 3: \$7.21
SF median household income	\$ 40,131	\$ 40,131	\$ 40,131	\$ 40,131	\$ 40,131	\$ 40,131	Fam. 1,2: \$19.29
Median income % of COL	91%	110%	75%	109%	128%	89%	Fam. 3: \$9.65

Notes: Basic family wage = hourly wage necessary per full-time worker to supply household income = basic area COL

Full time work calculated as 52 wk/yr. x 40 hr/wk = 2,080 hr/yr.

Source: California Budget Project, Making Ends Meet: How Much does It Cost to Raise a Family in California? Sacramento, October 1999

Child care is an important issue for families with young children and working parents. It has important influences on children's development, parents' travel and work schedules, quality of life, and family finances. San Francisco has licensed child care slots for 32% of its 58,900 children who have working parents (three-fifths of the children under age 14). This proportion is

better than California's statewide figure of 21%, but still far below the need here. The cost of licensed child care also represents a large share of household income for low and many middle income families. While there are numerous state and Federal programs to subsidize these costs for low-income families, they only partially meet of the need for quality child care slots.

San Francisco Child Care Supply/Demand, 1999

Children Living with Working Parents	Children		Children in care outside family	
	Number	Percent	Number	Percent
Children 0-5	25,899	57%	13,209	51%
Children 6-13	33,062	61%	6,612	20%
Total Children 0-13	58,961	59%		
Licensed Child Care Supply	18,994			
Licensed Child Care Supply as % of Need		32%		

Child Care Costs, San Francisco, 1999

	Average Annual Cost for 1 Child
Full-time care (in a center, infant <2 yrs.)	\$6,407
As % of full-time minimum wage earnings	54%
As % of full-time living wage earnings*	28%
As % of San Francisco median household income	16%

*Living wage earnings calculated for \$11.00/hr.

Risk Factors

Who we are
How we live
Our health

Many of the deaths in San Francisco can be attributed to seven well-known risk factors: tobacco use, poor diet and not enough exercise, excessive or ill-timed alcohol consumption, environmental toxins, guns, unsafe sex, and illegal drugs (primarily heroin). These risks, or determinants,

contribute to the leading causes of death in San Francisco in complex ways. The symbols in the table below indicate the approximate share of these causes of death that may be attributable to these determinants.

San Francisco Prevention Attribution Matrix for Leading Causes of Premature Mortality, 1998

Rank	Specific Cause of Death	Tobacco	Diet, lack of Exercise	Alcohol	Environ. Toxins	Guns	Sexual Behavior	Illegal Drugs
1	Ischemic heart disease (IHD)	●	●	+				
2	HIV Infection/AIDS			?			▲	●
3	Drug poisoning (mostly heroin overdose)			●				▲
4	Cerebrovascular (Stroke)	●	●	■+				■
5	Lung cancer	▲	?		■			
6	Lower resp. infection (Pneumonia)	●		■	■			
7	Suicide			●		●		■
8	Chronic obstr. Pulm. Disease (COPD)	▲			■			
9	Colorectal cancer	■	●	■				
10	Breast cancer	?	■	■				
11	Homicide			●		▲		●
12	Inflam/infect/cardiomyopathy		■	■				■
13	Chronic liver disease & cirrhosis			▲				■
14	Motor vehicle-traffic			●				■
15	Alcohol use (psych dx)			▲				

Specific cause of death ranking is by years of lost life (using a life expectancy table that begins with 82.5 years at birth). Ranking is based on 1998 mortality data. For methods see Aragon et al, *San Francisco burden of Disease and Injury: Mortality Analysis, 1990-1995*, San Francisco Department of Public Health, December 1998.

- ▲ Attributable fraction estimated to be greater than 40%
- Attributable fraction estimated to be between 10% and 40%
- Attributable fraction estimated to be between 2% and 10%
- +
 Protective effect of moderate alcohol consumption
- ?
 More than two studies but no consensus

Source: San Francisco Department of Public Health, Population Health and Prevention

Alcohol, Tobacco, & Other Drugs

How we live

SUBSTANCE ABUSE

The use of alcohol, tobacco and other drugs adversely affects the lives of all San Franciscans. Statistics for 1994 – 1996 indicate that San Francisco had the highest annual rate of drug related deaths among California counties (20.5 per 100,000). Related deaths due to heroin, cocaine, and speed increased slightly between 1996 and 1999.

Substance Abuse Facts and Figures

Impact of Substance Abuse

San Francisco has the highest rate of speed-related emergency room visits among U.S. cities, 65 per 100,000 (1996–97)

San Francisco has the highest concentration of retail liquor licenses among California counties (1997)

Substance Abuse and the Homeless

More than half (56%) of the deaths among the homeless were directly caused by drugs or alcohol (1997)

Eighty-nine percent of the deaths caused by drugs among the homeless were related to heroin (1997)

Seventy-five percent of homeless youth reported ever using heroin, speed, or cocaine (1993-95)

Injection Drug Use

There were an estimated 17,100 injection drug users (IDUs) living in San Francisco (1997)
6,017 IDUs were admitted to San Francisco drug treatment programs (FY 98-99)
3,332 injection drug users were HIV positive (1997)

Alcohol, tobacco and other drugs also play a key role in the amount and severity of disease and injury in San Francisco. Drug poisoning, primarily overdoses of heroin and cocaine, remains the third leading cause of premature death in San Francisco.

Summary of Substance Abuse Indicators by Drug, San Francisco, 1996–1999

Indicator	Drug				
	Heroin	Cocaine	Speed	Marijuana	Alcohol
CSAS clients* in treatment 1998-1999	5,447	2,710	1,002	738	3,731
Drug-caused deaths, 1997-98	130	101	27	--	--
Emergency-room drug mentions, 1998	2,386	1,843	616	394	--
Alcohol and drug arrests	7,214	2,098		2,370	7,160
Students using monthly, 1997	--	575	--	3,450	8,339

*Total number of unduplicated clients in treatment: 14,282

For the latest year statistics were available (1998), the use of drugs and/or alcohol directly caused or contributed to the death of 540 San Franciscans¹ with 117 of those deaths one hundred per cent attributable to alcohol. For these purposes, alcohol and drug-related deaths are those deaths that are directly attributable to alcohol or drug diagnoses and include both illicit drugs and legal drugs such as prescription and over the counter medications. These statistics do not include deaths by causes that are often closely associated with alcohol and drug abuse such as homicides, suicides, motor vehicle accidents, or other unintentional accidents.

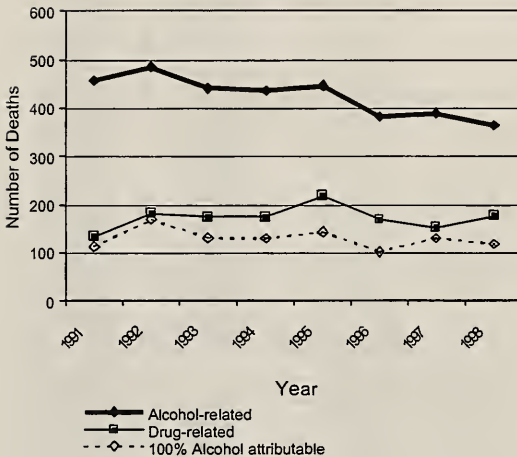
Source: Community Substance Abuse Services (CSAS), Epidemiology, San Francisco Department of Public Health

Alcohol, Tobacco, & Other Drugs

Who we are
How we live
Our health

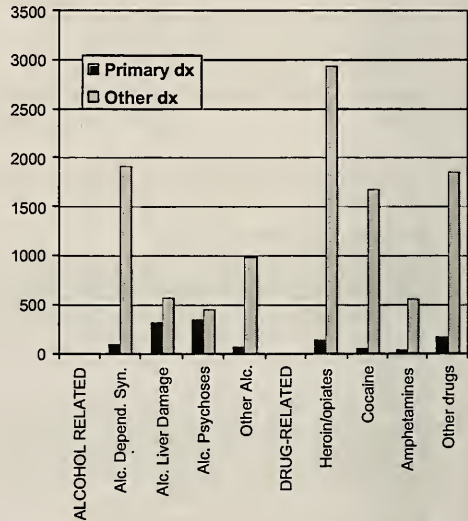
SUBSTANCE ABUSE—CONT.

**Alcohol and Drug Related Deaths,
San Francisco, 1991 - 1998**



Drug and alcohol use and abuse also account for a significant number of hospitalizations in San Francisco. While the number of hospitalizations attributable solely to drugs and/or alcohol are limited, the number in which drugs and/or alcohol are identified as a contributing factor is considerable. In 1998, there were a total of 3,074 hospitalizations resulting from the use of heroin and other opiates alone.

**Alcohol and Drug Related
Hospitalizations, San Francisco,
1997 - 1998**



Source: California Department of Alcohol and Drug Programs (California Department of Health Services Data)

Alcohol, Tobacco, & Other Drugs

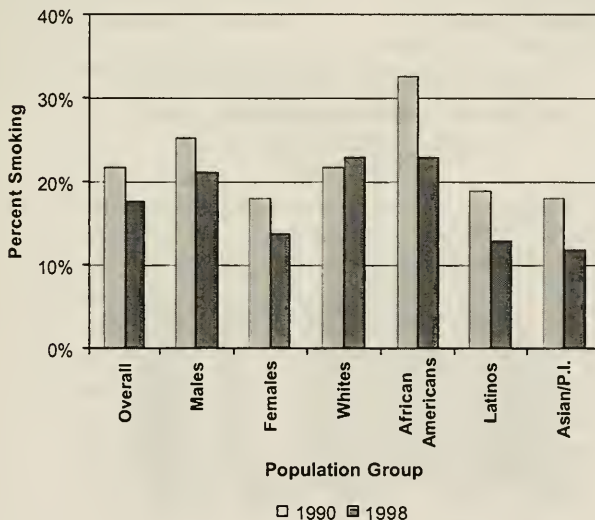
How we live

TOBACCO

From 1990 to 1995, about 10% of deaths in San Francisco were attributable to tobacco. Since 1990, smoking rates in San Francisco have decreased in the overall population

and in all ethnic groups except whites. In 1998, one-sixth of randomly surveyed San Francisco tobacco vendors illegally sold tobacco to people under age 18, indicating that tobacco is too readily available to underage youth.

***Percent of Smokers by Population Group.
San Francisco, 1990 and 1998***



Source: Tobacco Control Program, San Francisco Department of Public Health

Physical Inactivity

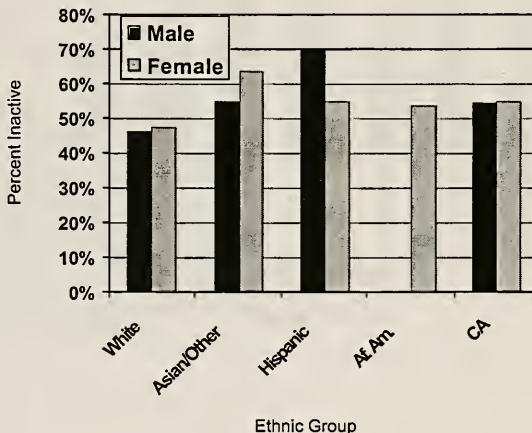
How we live

It has been estimated that physical inactivity in the U.S. has been implicated in perhaps a quarter of a million deaths a year, including about 25% of all chronic disease deaths. It affects cardiovascular risk through its influence on blood pressure, cholesterol, weight, and other mechanisms. In California, the prevalence in adults has remained fairly steady at just over half since 1984. There are big ethnic differences, with Hispanic men (70.4%) and women (66.2%) most likely to be inactive. Between 50% and 54% of African-American men and women are also likely to be sedentary. Asian/other women (63%) are more likely than men (44%) to be inactive. There are no age

differences, but there are differences by education. College graduates have significantly lower inactivity prevalence (44%) than those with no more than a high school education (63%).

In the Bay Area, white women have lower percents inactive than Hispanic (64%) or Asian/other women, but not different than African-American women, who are much less inactive than their statewide counterparts. White men are also significantly less inactive than Hispanic men. There were insufficient data to estimate the prevalence for Bay Area African-American men.

**Percent Physical Inactivity by Ethnicity
and Sex, San Francisco Bay Area,
1994 - 1996**



Sources: Gazzinga JM, Kao C, et. al. *Cardiovascular Disease Risk Factors Among California Adults, 1984-1996*. Sacramento: California Department of Health Services and UCSF, Institute for Health and Aging, 1998. pp. 22,26. Missing/insufficient data due to small subgroup sample size (<50). Data from Ca. BRFS. Bay Area counties are SF, Alameda, San Mateo, and Santa Clara.

Overweight

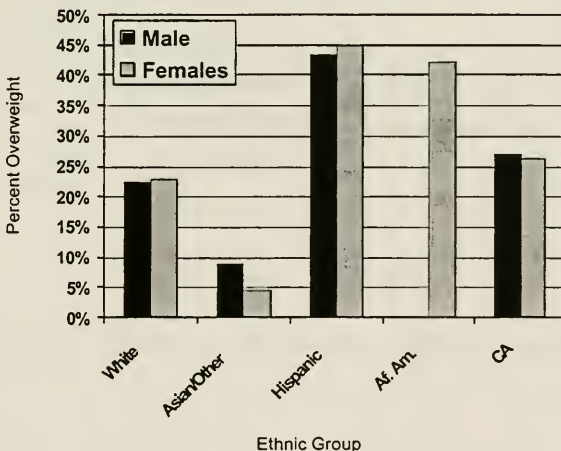
How we live

Overweight, measured by body mass index (a ratio between height and weight), is an important risk factor for heart disease, both in itself and also through its contribution to high cholesterol, high blood pressure and diabetes. Frequency of being overweight has been increasing among Californians, rising by over 50% from 1984 to 1996 -- by 41% for women and 60% for men. By 1996, 27% of adults were estimated to be overweight. Statewide, there were no differences by sex within any ethnicity, but Hispanic women (42.7%) and men (34.6%) and African-American women (40.2%) and men (37.0%) had significantly higher overweight prevalences than white women (24.2%) or men (25.1%). Proportion overweight rises across age groups through

ages 45-54, and then declines somewhat among older ages. The proportion overweight among college graduates (20.4%) is more than a third less than among those with no education beyond high school (31.4%).

In the Bay Area, percentages of those overweight did not differ by sex within ethnic groups. Hispanic men had significantly higher prevalence than white men, who were themselves much higher than Asian/other men. There were insufficient data for a reliable estimate for African-American men. Among women, African-Americans and Hispanics were higher than whites, who were higher than Asian/other women.

**Percent Overweight by Ethnicity and Sex,
San Francisco Bay Area,
1994 - 1996**



A convenient chart for determining body mass index and overweight is available at www.shapeup.org/bmi/chart.htm.

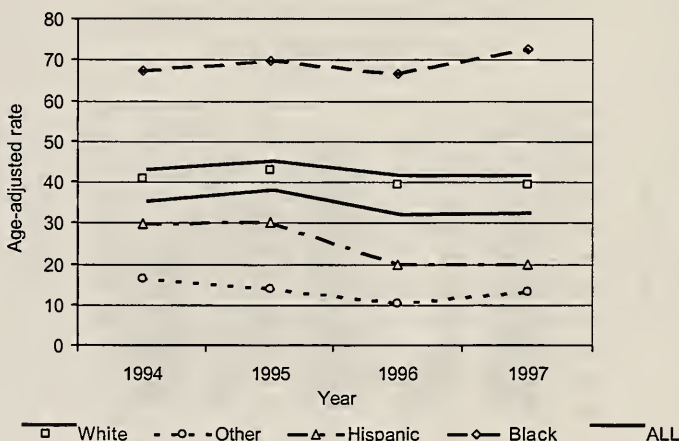
Sources: Gazzinga JM, Kao C, et. al. *Cardiovascular Disease Risk Factors Among California Adults, 1984-1996*. Sacramento: California Department of Health Services and UCSF, Institute for Health and Aging, 1998. pp. 22,26. Missing/insufficient data due to small subgroup sample size (<50). Data from Ca. BRFS. Bay Area counties are SF, Alameda, San Mateo, and Santa Clara.

UNINTENTIONAL INJURY, SUICIDE, AND HOMICIDE

Injuries account for a significant proportion of deaths, hospitalizations, and emergency responses in San Francisco. Injury death rates include both intentional (homicide and suicide), and unintentional injuries. Of the 293 unintentional injury deaths of San Francisco residents in 1997, 117 (42%)

were due to drug poisoning and 56 (19%) to motor vehicle traffic. Unintentional death rates are disproportionately higher in the African American population accounting for 20.8% of all unintentional deaths in 1997. African Americans also have higher death rates from homicides compared to other ethnic groups, while whites experience the highest suicide rates of all ethnic groups.

*Unintentional Injury Death Rates by Ethnicity,
San Francisco, 1994 - 1997*



Source: California Department of Health Services Website, Vital Query System

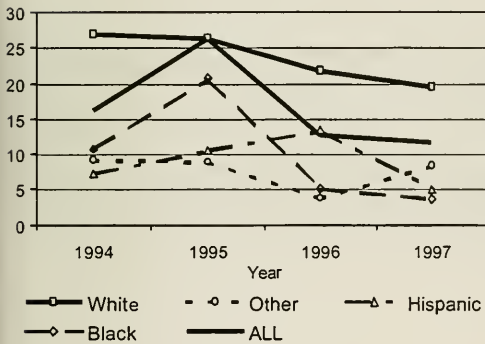
Injuries

How we live

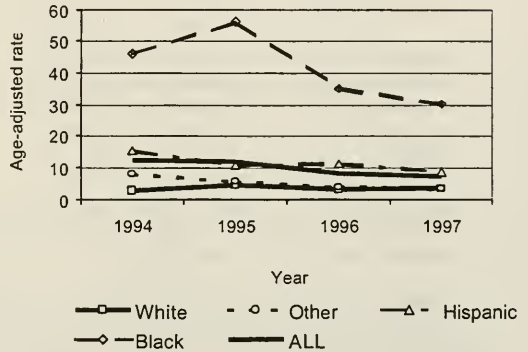
UNINTENTIONAL INJURIES, SUICIDES, AND HOMICIDE—CONT.

In 1997, 26% of 114 suicides and 62% of 53 homicides of San Francisco residents involved firearms. The Medical Examiner found alcohol in 28% and illegal drugs in 18% of suicide victims, and alcohol in 38% and illegal drugs in 44% of homicide victims.

Age-Adjusted Suicide Rate by Ethnicity, San Francisco, 1994 - 1997



Age-Adjusted Homicide Rate by Ethnicity, San Francisco, 1994 - 1997



Source: California Department of Health Services, Website, Vital Query System

Environmental Health

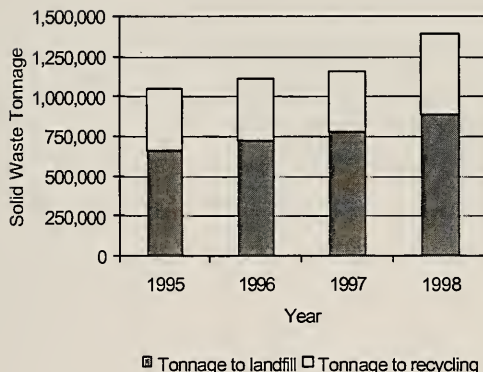
What we are
How we live
Our health

Three key indicators of the quality of our physical environment are solid waste generation, elevated blood lead levels and air quality.

SOLID WASTE

From 1995 to 1998, the amount of solid waste produced in San Francisco has increased. This increase may be related to the growing economy, including increased construction, tourism, and consumption. At the same time, the City's recycling efforts are paying off with a greater percentage of generated waste being recycled and diverted from landfills. However, San Francisco continues to send more to landfills than the Healthy People 2000 goal of 3.2 pounds per person of waste. In addition, the per capita amount, which includes waste from San Francisco's numerous non-resident workers and tourists, has also been increasing.

***Solid Waste Disposal
San Francisco, 1995-1998***



LEAD

The most common environmental sources of lead for San Francisco children with elevated blood lead levels are lead-based paint, lead-contaminated soil, and lead dust. From 1991 to 1998, the San Francisco Department of Public Health's Child Environmental Health Promotion Program (CEHP, formerly Childhood Lead Prevention Program) identified up to 106 children annually with blood lead levels high enough to warrant case management services. The number of cases dropped to 37 in both 1997 and 1998. These numbers should not be confused with rates, since only positive screening results are reported, and we do not know how many children were tested each year.

Source: R Bhatia, MD, "Annual Report to the Health Commission: Status of Environmental Health Programs in San Francisco," SFDPH, March, 2000

AIR QUALITY

The Federal Clean Air Act directs the EPA to develop and promulgate health based standards for certain "criteria" ambient air pollutants including ozone, respirable particulate matter (PM₁₀), sulfur dioxide, nitrogen dioxide, carbon monoxide, and lead. Since 1993, the state air pollution standards for ozone, carbon monoxide,

nitrogen dioxide, and sulfur dioxide have not been exceeded in San Francisco. However, there have been several occasions on which daily concentrations of particles have been higher than the 24-hr PM₁₀ standard. In the Bay Area, major sources of PM₁₀ include industrial emissions, motor vehicles, road dust, construction, demolition, and residential wood smoke.

San Francisco Air Pollution Maximum Concentrations and Exceedances based on California Standards, 1993 - 1997

Pollutant	California Standards	1995		1996		1997		1998	
		Max	X*	Max	X*	Max	X*	Max	X*
Ozone ¹	9 pphm (1-hr avg.)	9	0	7	0	7	0	5	0
Carbon Monoxide ²	9 pphm (1-hr avg.)	4.4	0	3.7	0	4.2	0	4.0	0
Nitrogen Dioxide ¹	25 pphm (1-hr avg.)	9	0	8	0	7	0	8	0
Sulfur Dioxide ³	50 ppb (24-hr avg.)	7	0	8	0	6	0	6	0
PM ₁₀ ^{3,4} (µg/m3)**	30 µg/m3 (ann. Geo. Mean)								
	50 µg/m3 (24-hr avg.)	22.1	0	21.4	2	22.4	0	20.1	1

1 = Avg. 1-hour maximum; 2 = Avg. 8-hour maximum; 3 = 24-hour avg.; 4 = annual geometric mean

*X = # exceedances based on state standards, which are stricter than national standards for Ozone, Sulfur Dioxide, and PM₁₀

** PM₁₀ is measured every 6 days, so the number of exceedances can be estimated as 6 times the number shown

Sources: Bay Area Air Quality Management District; data available through February, 2000; and R Bhatia, MD, "annual report to the Health commission: Status of Environmental Health Programs in San Francisco," SFDPH, March, 2000

Access to Health Care

How we live
Our health

ACCESS TO HEALTH CARE

Access to health care services is a significant issue in San Francisco, as it is throughout California and the rest of the U.S. Lack of access to preventive and ongoing health care services leads to higher rates of preventable disease and injuries and poorer health

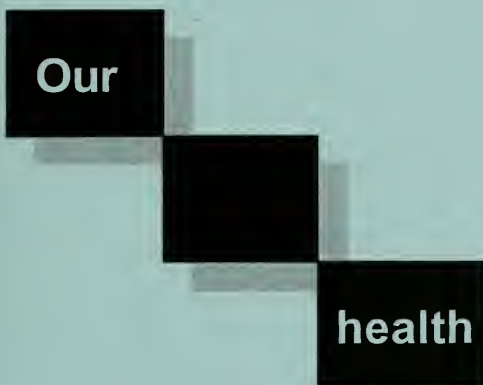
outcomes from illness and injury. A common indicator of access to health care services is the availability of health insurance. San Francisco is similar to the rest of California in that the majority of residents without health insurance are employed (full-time or part-time) or are members of families with working adults.

Health Care Coverage Status, San Francisco, 1997

Health Coverage Status	% of Population	Number of Residents
Employer-based coverage	53%	407,900
Individually purchased	6%	46,400
Publicly funded		
Medi-Cal	9%	73,200
Medicare	15%	115,500
Uninsured	17%	130,000
Uninsured Category	% of Uninsured	
Working adults	68%	88,000
Indigent adults	14%	18,000
Other adults	8%	11,000
Children and youth	10%	13,000

Source: Mayor's Blue Ribbon committee on Universal Health Care, *Achieving Health Insurance for San Francisco's Uninsured*, May, 1998.

San Francisco



Our health

Our health

Our health

Our health

Our health

Our health

Our health

Our health

Our health

Our health

Our health

Our health

Our health

Our health

Our health

Our health

Our health

Our Health

Who we are
How we live
Our health

Our health is largely a product of who we are and how we live. Our data show how many people face a variety of diseases and injuries. Our data do not show all disabling conditions, nor do they illustrate the quality of life that people experience. However, these data do provide us with a measure of many of the pressing health issues that we must tackle as individuals, as communities, and as a city.

Major Causes of Death

Our health

AGE ADJUSTED MORTALITY RATES

Major causes of death are a standard component of health indicator data. Healthy People 2000 objectives are set for many cases of mortality, which allow for national, state, and local comparisons.

This table shows how San Francisco compares to California and the national objectives in the most recent data available. San Francisco was among the best counties in the state for lung cancer mortality, but continues as the worst for drug-related deaths.

Age Adjusted Mortality Rates for Major Causes of Death, San Francisco, 1994 - 1998

CA County Ranking	CAUSE	1996 - 98 Deaths/yr. (avg.)	Crude Death Rate	San Francisco Age- Adjusted Death Rate	95% Confidence Limits		State Age- Adjusted Death Rate	Nat'l Obj.	Obj. Met
					Lower	Upper			
27	ALL CAUSES	6,961	895.5	439.4	426.9	451.8	425.7	N/E	
31	CORONARY HEART DISEASE	1,689	217.3	83.8	78.9	88.6	93.9	100.0	YES
27	CEREBROVASCULAR DISEASE	531	68.2	24.9	22.3	27.5	25.3	20.0	NO
12	ALL CANCERS	1,503	193.3	102.9	97.0	108.8	110.3	130.0	YES
6	LUNG CANCER	363	46.7	25.1	22.2	27.9	30.0	42.0	YES
12	FEMALE BREAST CANCER	111	28.3	16.3	12.9	19.8	18.3	20.6	YES
24	UNINTENTIONAL INJURIES	295	38.0	29.9	26.1	33.7	24.2	29.3	
	MOTOR VEHICLE								
4	ACCIDENT	58	7.4	7.0	4.9	9.0	11.4	14.2	YES
38	HOMICIDE	52	6.7	7.5	5.2	9.7	9.0	7.2	NO
35	SUICIDE	110	14.2	11.3	9.0	13.6	9.4	10.5	NO
58	DRUG-RELATED DEATHS	166	21.4	18.1	15.2	21.0	7.5	3.0	NO
16	FIREARM INJURIES	63	8.1	8.3	6.0	10.6	1.6	11.6	NO

Age adjusted to standard 1940 US population.

Major Causes of Death

What are the
leading causes of death?
Our health

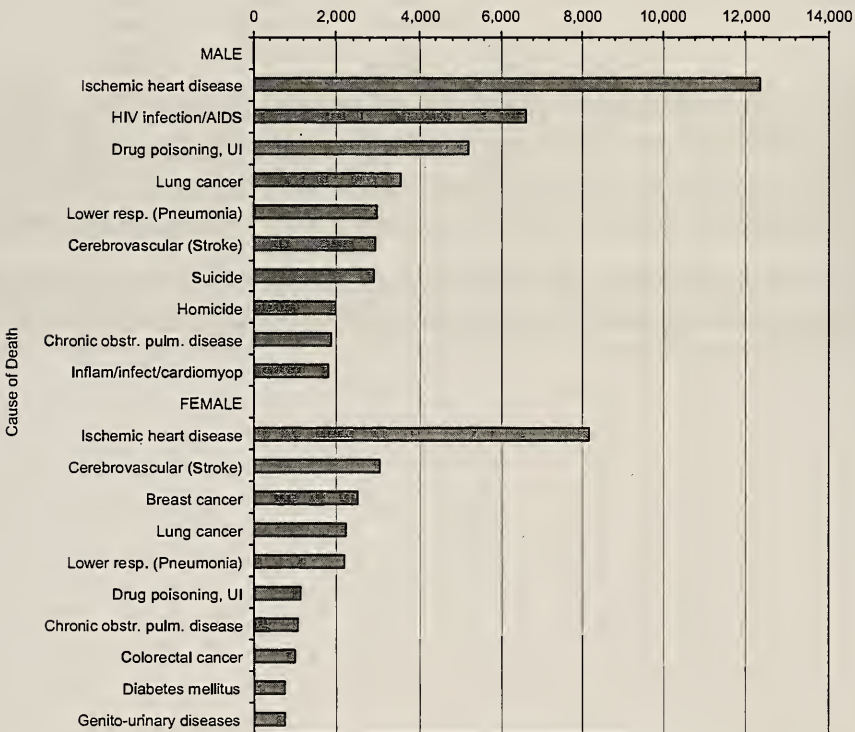
PREMATURE DEATH

Leading causes of death are also analyzed by measuring Standard Expected Years of Life Lost (SEYLL) for specific causes of death. By giving greater weight to deaths of younger people, this measure emphasizes premature mortality. The years of life lost for a person dying are based on life

expectancy for persons of their age at the time of death. Ischemic heart disease is the leading cause of premature death for men and women. AIDS continues as the second leading cause of death for men. However, drug poisoning, mainly heroin overdose, has replaced lung cancer as the third leading cause of premature death for men and has become the sixth leading cause for women.

Leading Causes of Premature Death by Sex, San Francisco, 1998

Expected Years of Life Lost



Source: State of California Vital Records, 1998

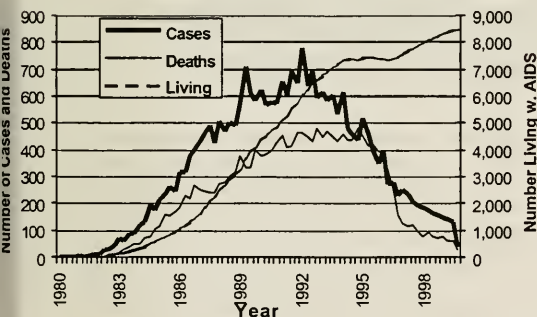
Communicable Disease

Our health

HIV/AIDS

From 1990 to 1996, AIDS was the leading cause of preventable death in San Francisco as measured by expected years of life lost. However, due to prevention efforts and the increased efficacy of new drug therapies, the number of deaths attributable to AIDS has been declining since 1995 while the number of persons living with AIDS and HIV has been increasing. In addition, the number of new cases of AIDS diagnosed since 1992 has been declining, making AIDS the second leading cause of premature mortality in San Francisco in 1997 and 1998. Although AIDS affects people of all genders, ethnicity, and sexual orientation, in San Francisco, it remains predominantly a disease of men who have sex with men and intravenous drug users.

AIDS Cases, Deaths, and Numbers of Persons Living with AIDS, San Francisco, 1990 - 1999



AIDS Cases by Transmission Category, Ethnicity, and Year of Diagnosis, San Francisco, 1990 - 1999

Transmission Category	Number of Cases				Difference 1990 - 1999	
	1990	1992	1995	1999*	Cases	% Change
Gay/bi men	1857	2058	1281	300	-1557	-83.8
Injection drug users (IDU)	124	217	174	80	-44	-35.5
Gay/bi men + IDU	290	341	201	57	-233	-80.3
Lesbian/bi fem + IDU	3	8	4	1	-2	-66.7
Hemophiliac	2	7	5	1	-1	-50.0
Heterosexual	26	42	32	10	-16	-61.5
Transfusion	13	11	10	2	-11	-84.6
Other	12	19	17	11	-1	-8.3
Pediatric (0-12)	4	2	3	2	-2	-50.0
SEX						
Male	2266	2591	1640	424	-1842	-81.3
Female	65	114	87	40	-25	-38.5
ETHNICITY						
White	1772	1937	1183	277	-1495	-84.4
Af. American	258	331	259	83	-175	-67.8
Hispanic	220	342	212	79	-141	-64.1
API/Other	66	71	65	22	-44	-66.7
Native Am.	15	24	8	3	-12	-80.0
TOTAL	2331	2705	1727	464	-1867	-80.1

* Cases reported may not be complete in later years.
Cases reported by year of diagnosis.

Source: Quarterly AIDS Surveillance Report, San Francisco Department of Public Health, AIDS Cases Reported through December, 1999 (January, 2000)

Communicable Disease

What we see
how we live
Our health

SEXUALLY TRANSMITTED DISEASES (STDs)

Rates for sexually transmitted diseases (STDs) decreased significantly in San Francisco between the late 1970s and 1998. Between 1998 and 1999, there was a slight decrease in STD rates in the general population. However, rates for gonorrhea, chlamydia, and syphilis within specific

populations, such as adolescents, actually increased. Last year, San Francisco met the Healthy People 2000 objectives for overall rates of congenital syphilis and for rates of gonorrhea in women and adolescents, and within the African American community. Healthy People 2010 sets the objective for the reduction of gonorrhea at 19 cases per 100,000 over the next ten years within all ethnic and age groups.

Selected San Francisco STD Rates, San Francisco, 1997 – 1999

Disease	Number of cases			San Francisco Rate	
	1997	1998	1999	1998	1999
Gonorrhea: all groups	1,497	1,852	1,593	255.8	220
➤ African American	473	604	565	791.2	740.1
➤ Asian	53	60	61	29.2	29.7
➤ Hispanic	129	179	188	177.7	186.7
➤ White	556	679	676	201.4	—
Adolescents (< 20)	181	250	205	492.7	579.7
Chlamydia	2,253	2,611	2,670	—	368.8
Early Syphilis	73	40	41	5.5	5.7
Congenital Syphilis	2	1	1	12.3	—

Source: San Francisco Department of Public Health, Annual STD Summary, 1998 and “San Francisco Monthly STD Report, data for December, 1999”, (January, 2000)

Communicable Disease

Our health

TUBERCULOSIS

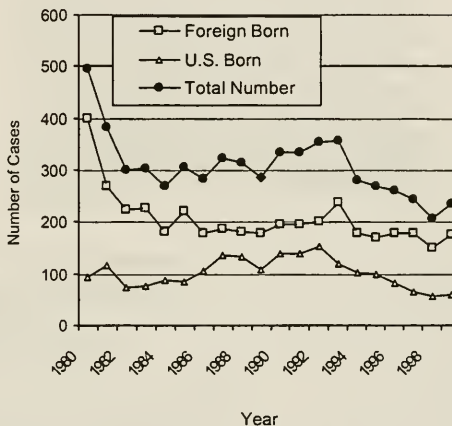
In 1999, there were 235 documented cases of Tuberculosis (TB) in San Francisco. This represents only a slight increase from last year's lowest ever recorded number of new cases (207). The increase occurred among African Americans, Southeast Asians and Filipinos while the number of cases in whites decreased last year. The rates are well above the Healthy People 2010 objective for new TB infection of 1 per 100,000 for all ethnic and age groups.

Tuberculosis Rates by Ethnicity Compared to California and United States Rates, 1999

Ethnic Group	SF Rate
Asian/Pacific Island	74.4
African American	44.5
Hispanic	23.8
White	7.1

Tuberculosis continues to disproportionately affect those populations who pose the greatest challenge with regards to medication compliance and monitoring; immigrants, the homeless, and persons with AIDS. In 1999, 74.4% of new active cases of TB occurred among foreign-born residents of San Francisco. The largest majority of foreign-born cases occurred in Asian immigrants, mainly Chinese, Filipino, and Southeast Asians. Of those persons tested for AIDS (111 cases) 25.2% tested positive, and the homeless represented another 14.9% of new active TB cases in 1999.

Foreign-Born Tuberculosis Cases, San Francisco, 1980-1999



Drug-resistant strains of TB peaked in 1996 at 20.4% of new cases. In 1999 15.7% of cases were documented as drug resistant.

Non-Communicable Disease

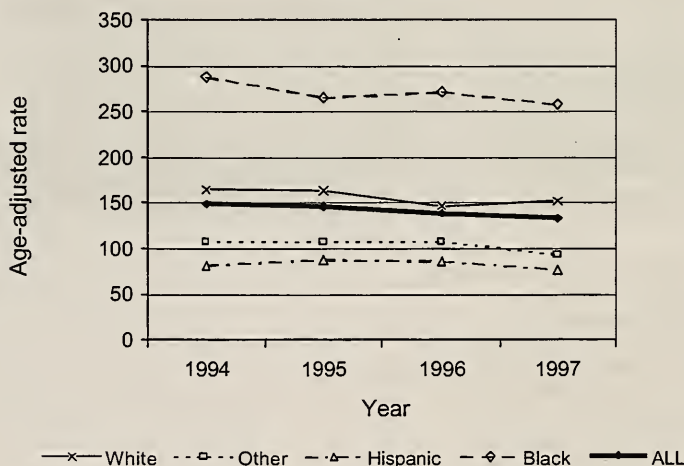
Our health

CARDIOVASCULAR DISEASE

Cardiovascular disease includes ischemic heart disease (IHD), stroke, and other forms of heart disease. IHD is the leading cause of death for both men and women, and stroke is among the leading causes each year. Rates have been declining somewhat among all groups, but there are still very large differences across ethnicities in San Francisco (as there are elsewhere). African Americans have by far the highest rates,

well over twice that of the groups with the lowest rates, Asian/others and Hispanics. Whites' rates are inbetween, significantly lower than African Americans but still significantly higher than the other groups. IHD and stroke mortality rates among males of each ethnicity are significantly higher than rates among females. A large part of these differences can be attributed to differing exposures to well-established risks (see pp 15).

**Age Adjusted Cardiovascular Death
Rates by Ethnicity, San Francisco,
1994 - 1997**



Source: California Department of Health Services Website, Vital Query System

Non-Communicable Disease

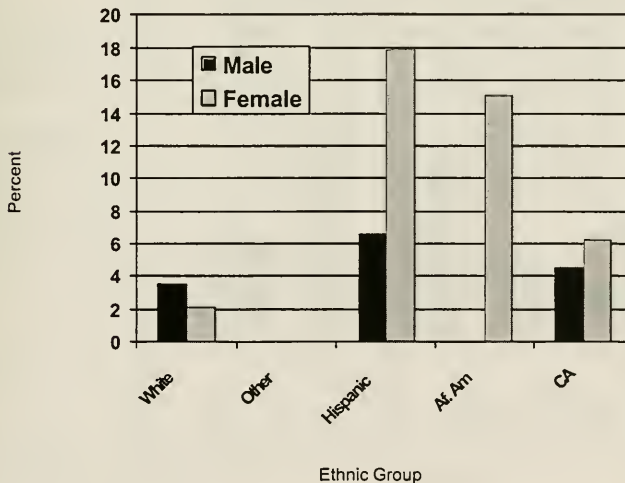
Our health

DIABETES

People with Diabetes are 2 to 4 times as likely to die from coronary heart disease and twice as likely to die from stroke as people without diabetes. More than 80% of people with diabetes die from some form of cardiovascular disease. Diabetes prevalence increases with age and body weight, and is lower among college graduates (4%) than among those with no more than a high school education (7.2%). Diabetes has been increasing among California adults since the mid-1980s,

especially among women. Statewide, Hispanics (12.9%) and African-Americans (14.5) have higher rates than whites (4.3%). Prevalence by ethnicity and sex for the Bay Area (San Francisco, San Mateo, Santa Clara, and Alameda counties) are shown in the graph below. For those groups with sufficient data, the prevalence among Hispanic and African-American females was significantly greater than among white females. Where bars are missing, data were insufficient to produce a reliable estimate for that group.

*Diabetes Prevalence by
Ethnicity and Sex, San Francisco
Bay Area, 1994 - 1996*



Source: Gazzinga JM, Kao C, et. al. *Cardiovascular Disease Risk Factors Among California Adults, 1984-1996*. Sacramento: California Department of Health Services and UCSF, Institute for Health and Aging, 1998. pp. 22,26. Missing/insufficient data due to small subgroup sample size (<50). Data from Ca. BRFSS. Bay Area counties are SF, Alameda, San Mateo, and Santa Clara.

Non-Communicable Disease

TO US AND
TO WE E
Our health

HIGH BLOOD PRESSURE (HYPERTENSION)

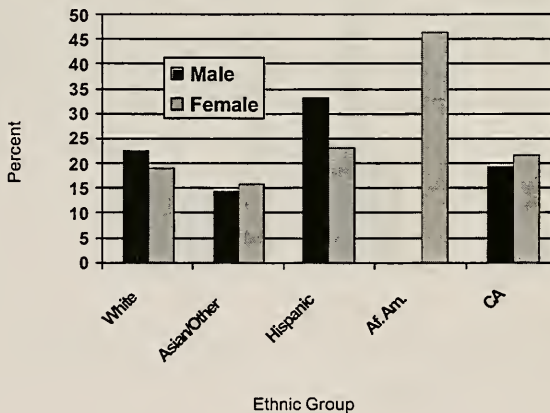
High blood pressure (HBP) is the single most important risk factor for stroke. People with uncontrolled HBP are as much as seven times more likely to develop stroke than others, and three to four times as likely to develop heart disease as well. Most high blood pressure can be prevented or controlled by a combination of regular exercise, weight control, limiting sodium and alcohol in the diet, and, if necessary, prescription medications.

HBP prevalence has stayed relatively steady since the mid-1980s. Prevalence increases greatly with age. Sex differences in prevalence are relatively small, but there

are significant ethnic differences. African-Americans have the highest prevalence; with men (41.5%) having significantly higher prevalence than Asian/other (15.6%), Hispanic (22.1%), or white (22.8%) men, and African American women (35%) being higher than white women (23.7%).

Bay Area prevalences are shown in the figure below for groups for which data were sufficient to make reliable estimates. There are no significant male-female differences within ethnic groups. Among men, Hispanics have significantly higher prevalence than Asian/other, and African-American women have significantly higher prevalence than women of any of the other ethnic group.

High Blood Pressure Prevalence in San Francisco Bay Area, 1994 - 1996



Source: Gazzinga JM, Kao C, et. al. *Cardiovascular Disease Risk Factors Among California Adults, 1984-1996*. Sacramento: California Department of Health Services and UCSF, Institute for Health and Aging, 1998. pp. 22,26. Missing/insufficient data due to small subgroup sample size (<50). Data from Ca. BRFS. Bay Area counties are SF, Alameda, San Mateo, and Santa Clara.

Non-Communicable Disease

Our health

CANCER

From 1992 to 1996, the highest rate of cancer incidence (occurrence) among males was for prostate cancer, followed by lung cancer. However, lung cancer had three times the death rate of prostate cancer. Among females, breast cancer had

the highest incidence, more than double that of lung cancer, but the death rate from lung cancer was slightly higher than that of breast cancer. There are important differences by sex and ethnicity in both cancer incidence and morbidity.

Age -Adjusted San Francisco Cancer Incidence Rates by Sex and Ethnicity, 1992 - 1996

	ALL	ALL				Males						Females					
	ALL	M		F		White	Af. Am.	Latino		Asian/ Other	White	Af. Am.		Latino	Asian/ Other		
	No.	No.	Rate	No.	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	
All cancers	21,160	12,267	*543.3	8,893	329.6	**636.7	***771.8	*387.5	332.1	*398	*380.8	233.3	245.5				
Prostate cancer	2,911	2,911	135.7			**148.9	***255	*97.4	72.5								
Lung cancer	2,593	1,516	*71.3	1,077	38.1	76.2	125.6	32.6	60.7	*47.8	*58.0	21.2	25.9				
Breast cancer (invasive)	2,568			2,568	101.1					*131.8	*112.5	69.0	63.2				
Colorectal cancer (invasive)	2,310	1,153	*52.5	1,157	37.7	*54.7	***72.5	37.0	48.4	*39.9	37.0	26.9	*38.4				
Kaposi's sarcoma	1,659	1,647	57.4	12	0.3	85.3	47.8	50.0	6.1	0.5							
Non-Hodgkin's lymphoma	1,392	1,074	*42.8	318	11.3	***57.5	*33.8	*38.0	15.4	12.4	11.2	10.0	9.0				
Bladder cancer	717	511	*23.4	206	6.4	***33.1	17.9	13.3	11.2	*9.0	*7.9	3.5	3.3				
Mouth/oropharynx cancers	575	396	*18.8	179	6.7	21.0	*28.1	13.0	15.1	*7.1	*7.4	1.8	*7.9				
Breast cancer (in situ)	542			542	23.1					*27.9	*28.4	11.6	18.0				
Corpus uteri cancer	523			523	20.5					*25.6	*20.2	9.4	15.9				
Stomach cancer	488	294	*13.5	194	6.4	11.4	*24.2	10.9	15.0	5.5	5.0	5.5	8.5				
Melanoma/skin cancers (invasive)	457	273	*11.7	184	7.3	21.2				*13.9		2.1					
Pancreas cancer	449	215	*9.9	234	7.1	10.6	*15.9	9.7	7.1	7.2	***15.4	5.0	4.8				
Leukemia	437	237	*11.7	200	8.2	12.7	13.7	10.0	9.4	9.4	7.0	5.6	7.0				
Liver cancer	391	297	*14.0	94	3.4	8.6	*18.9	10.0	*22.7	1.7	4.7	2.8	*5.9				
Ovarian cancer	360			360	14.4					***20.2	9.9	12.1	9.0				
Kidney	350	191	*8.9	159	6.3	*9.8	*13.0	9.6	5.4	*6.4	*13.8	7.1	3.0				
Cervix uteri cancer	258			258	10.3					7.8	12.5	*15.9	9.9				
Brain & N.S. cancer	250	155	*7.7	95	3.8	9.4	6.6	5.8	6.0	6.4	3.7	1.6					
Mult. myeloma	190	105	4.7	85	3.1	4.8	***13.0	3.1	2.7	2.5	***12.1	2.5	1.5				
Esophageal cancer	188	136	*6.4	52	2.0	*6.3	***16.6	1.9	4.9	*2.8	*4.2		0.7				
Colorectal cancer (in situ)	149	89	*4.1	60	2.0												

Age adjusted to standard 1970 US population, rates per 100,000 per year

Ranked by total number of incident cancers

* significantly higher than lowest ethnicity group

**significantly higher than next lower ethnicity group

***significantly higher than all other ethnicity groups

Source: NCCC, Cancer Incidence & Mortality in the San Francisco Bay Area, 1988-1996. March, 1999

Non-Communicable Disease

How we are
living
Our health

Age-Adjusted Cancer Mortality Rates, San Francisco, 1992 - 1996

	ALL	Male		Female		Male Rates				Female Rates			
	No.	No.	Rate	No.	Rate	White	African-American	Latino	Asian/Other	White	African-American	Latino	Asian/Other
All cancers	7,227	4,141	*188.2	3,086	130.1	**206.3	***317.8	131.2	141.8	*141.5	***190.9	83.9	90.1
Lung cancer	1,967	1,152	*53.8	815	27.1	**57.9	***101.4	26.3	*42.6	*35.5	*45.2	10.9	16.2
Colorectal cancer	883	446	*19.6	437	13.0	*21.8	*28.8	14.0	15.0	*13.6	*18.5	7.7	13.2
Breast cancer	568			568	20.3					*23.6	***35.3	13.9	12.8
Prostate cancer	483	483	20.3			**23.2	***50.5	*17.1	8.0				
Pancreas cancer	397	177	8.1	220	6.4	*9.7	10.6	7.5	5.1	*7.4	*12.6	3.8	3.9
Non-Hodgkin's lymphoma	343	184	*8.1	159	4.8	9.4	6.0	9.2	5.5	6.1	4.6	4.0	3.0
Stomach cancer	304	184	*8.3	120	3.8	5.6	*18.4	*8.5	*9.8	2.9	3.6	4.4	5.0
Liver cancer	293	221	*10.5	72	2.4	6.4	*15.8	8.0	*16.3	0.9	3.1		4.9
Leukemia	289	150	*7.0	139	4.9	7.5	9.6	5.8	5.0	5.0	4.0	4.5	5.0
Ovarian cancer	198			198	7.2					*9.8	5.0	7.0	3.6

Age adjusted to standard 1970 US population, rates per 100,000 per year

Ranked by total number of deaths. Rates not reported for fewer than 5 cases.

* rate significantly higher than lowest rate of other ethnicity groups

* * rate significantly higher than next lower ethnicity group rate

* **rate significantly higher than rates of all other ethnicity groups

Source: NCCC, Cancer Incidence & Mortality in the SF Bay Area, 1988-1996. March, 1999

Non-Communicable Disease

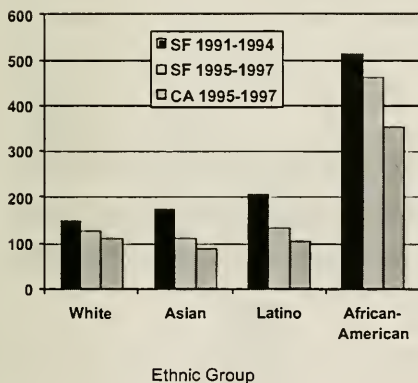
Our health

ASTHMA

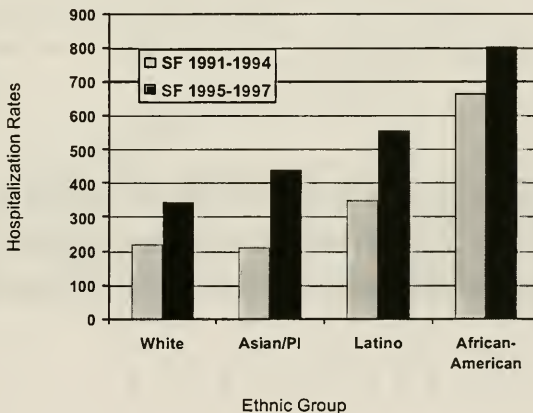
San Francisco's hospitalization rate for asthma between 1995 – 1997 was 160 per 100,000. This was slightly higher than that for the State as a whole (120 per 100,000). However, when hospitalization rates are examined by age and ethnicity, a very different picture unfolds. In San Francisco

between 1995 – 1997, children (age 0-14) experienced nearly double the hospitalization rate for asthma than did the general San Francisco population (317 per 100,000), and African Americans of all ages, experience more than three times the general hospitalization rate for asthma (463 per 100,000).

Asthma Hospitalization Rates by Ethnicity, San Francisco 1991–1997 and California 1995–1997



Asthma Hospitalization Rates, Children 0–14, San Francisco, 1991–1997



Sources: CDHS, Ca. County Asthma Hospitalization Chart Book, August, 1997
 CDHS, Ca. County Asthma Hospitalization Chart Book, Draft not released
 J. Mann, Asthma in San Francisco, SFDPH, 2/18/00 draft

Disability

People are
not healthy
Our health

We have no systematic data showing the number of San Franciscans whose ability to function in daily living are hampered to various degrees by disabilities. Among those who are more severely disabled, such that their ability to work is seriously compromised, many will receive Supplemental Security Income (SSI). This federal program is administered by the Social Security Administration; recipients' benefits are supplemented by the state SSP program.

These data, from December 1998, show that 46,000 San Franciscans received

benefits from the program. Of these, 44% were classified as aged and 54% as blind or disabled. This differs markedly from the statewide program proportions of 31% aged and 69% blind or disabled. Accordingly, a much higher proportion of SSI recipients were over 65 in San Francisco (56%) than in California (44%), and a lower proportion were under age 18 (2.1%, compared to 7.6% statewide). Almost a third of San Franciscans on SSI also received social security retirement, survivor or disability benefits.

Supplemental Security Income Recipients San Francisco, 1998

	Total	Category		Age			SSI w. OASDI	Amount of Payments (\$1,000)
		Aged	Blind & Disabled	< 18	18-64	65+		
CA	1,042,002	324,774	717,228	78,861	505,786	457,355	393,012	496,115
Part of Total	1.000	0.312	0.688	0.076	0.485	0.439	0.377	
SF	46,036	20,096	25,940	975	19,112	25,949	14,727	23,452
Part of Total	1.000	0.437	0.563	0.021	0.415	0.564	0.320	
SF as % of CA	4.4%	6.2%	3.6%	1.2%	3.8%	5.7%	3.7%	4.7%

Source: Social Security Administration, SSI Recipients by state and County, December 1998, Table 3
http://www.ssa.gov/policy/pubs/pubs_pages/pubs_programDatabyGeographic.htm

Mental Health

Our health

MENTAL ILLNESS

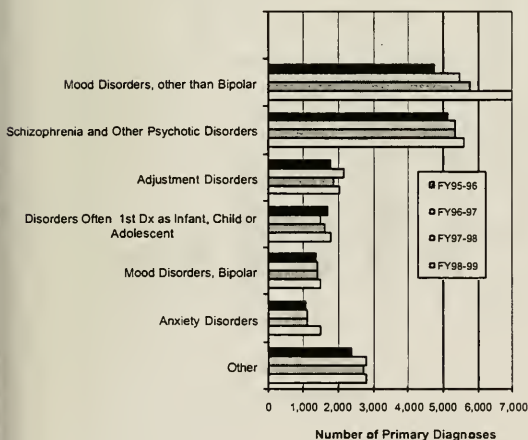
San Francisco Department of Public Health Community Mental Health Services (CMHS) serves San Francisco residents with severe mental illness. CMHS's client profile by primary diagnoses of clients is consistent with other U.S. jurisdictions providing services to individuals with severe mental illness.

The total number of CMHS clients increased in 1998-99, reflecting the initiation of the San Francisco Mental Health Plan and the Plan's community outreach efforts to make

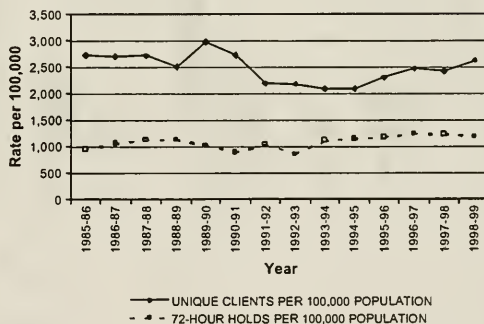
eligible persons aware of services. According to state law, individuals who are a danger to themselves or others or are greatly mentally disabled may be detained for up to 72 hours ("5150s") for evaluation and treatment.

Recent data on the occurrence of less severe mental health conditions and needs in the population at large in San Francisco are not available. However, according to a World Health Organization Study of years of life lost to death or disability, depression is the leading cause of years lost to disability in countries with established market economies like the United States.

Primary diagnoses of Community Mental Health Services Clients, San Francisco, FY 1995-1996 to FY 1998-1999



Community Mental Health Services Client and 72-Hour emergency Hold (5150s) Rates, San Francisco, FY 1985-86 to FY 1998-99



Source: Mental Health Section, San Francisco Department of Public Health
CJL Murray and AD Lopez eds., *The Global Burden of Disease*, vol. 1, Harvard University Press, 1996.

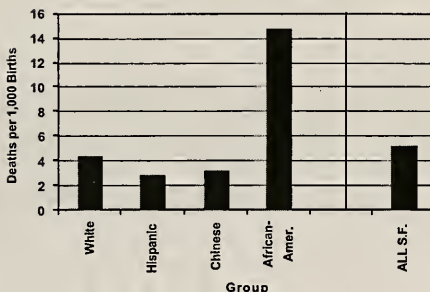
Maternal and Child Health

Our health

INFANT MORTALITY

In 1998, there were 8,149 births to San Francisco residents. Infant mortality is recognized worldwide as a core indicator of a community's health status. In 1998, there were 42 deaths of infants less than 1 year old in San Francisco, resulting in an infant death rate of 5.2 per 1,000 live births. San Francisco has achieved the Healthy People 2000 goal of reducing the infant mortality rate to no more than seven per 1,000 live births, but there is a significant disparity in infant mortality between African Americans and other Ethnic groups.

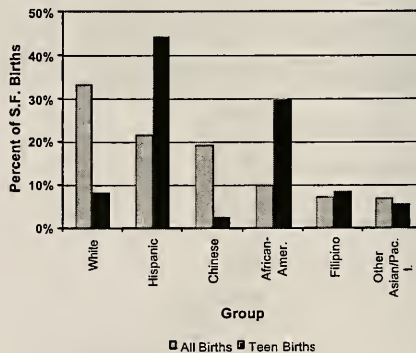
Infant Mortality Rate, by Ethnicity, San Francisco, 1998



TEEN PREGNANCY

Adolescent childbearing has important health and social consequences for young women, their babies, and their families. Pregnant adolescents are more likely to have inadequate prenatal care. The younger the adolescent mother, the more likely she is to have poor pregnancy outcomes such as preterm delivery and a low birthweight infant, and to be chronically poor as an adult. In 1998, there were 499 births to San Francisco teens; 61.5% were ages 18 to 19, 32% were ages 16 to 17, and 7% were ages 13 to 15. African American and Hispanic adolescents account for a disproportionate share of births to adolescent mothers compared to the distribution of all births in San Francisco by race and ethnicity.

Distribution of Births by Ethnicity, All Ages and Teen births, San Francisco, 1998



Source: San Francisco Department of Public Health, Vital Records, San Francisco, 1998

Maternal and Child Health

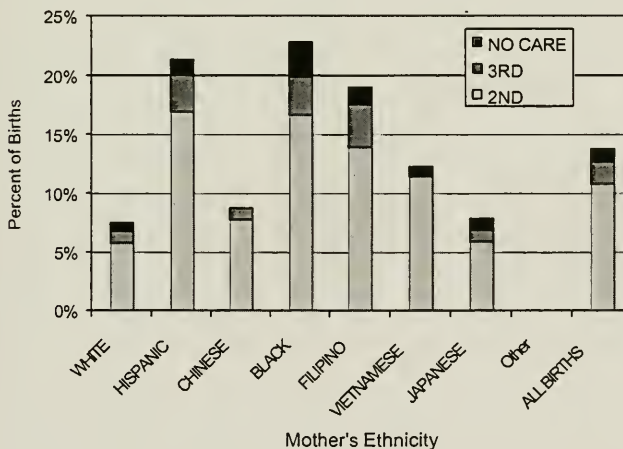
Our health

LATE PRENATAL CARE (PNC)

To promote the healthiest pregnancies and birth outcomes it is considered important for women to come in for a prenatal checkup during the first trimester (i.e., during first three months) of their pregnancies. Early prenatal care (PNC) is often used as an indicator of how well a population group is connected to regular sources of health care.

In San Francisco in 1998, 86% of the births were preceded by early PNC; the national Year 2000 objective is 90%. However, later care is unequally distributed by ethnicity (shown in graph) and age (not shown), with more than 20% of African-American (24%) and Hispanic (21%) births having late or no prenatal care, and Filipinos almost as much (19%).

*Trimester Prenatal Care Began by Mother's Ethnicity
San Francisco, 1998*



Source: San Francisco Department of Public Health, AVSS Birth Certificates and Records
Prepared by Population Health, Records and Statistics, September, 1999.

Maternal and Child Health

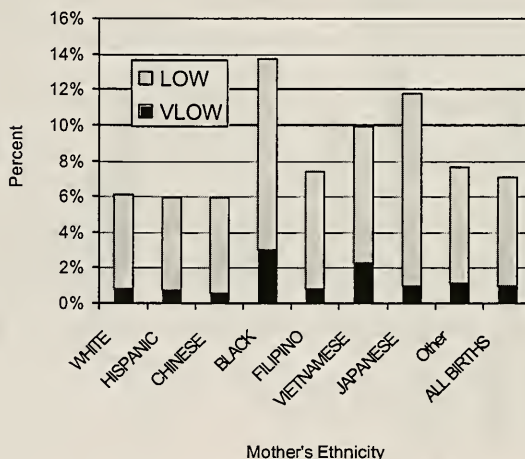
Our health

LOW BIRTH WEIGHT

Low birth weight (birth weight less than 2500 grams) increases infants' risk of infant mortality and other health problems, and very low birth weight (birth weight less than 1500 grams) increases these risks even

more. In San Francisco as elsewhere, increased low birth weight rates are associated with higher prevalence of late prenatal care in most populations, as seen here for African-American births. That association does not appear to hold as well among Hispanics.

**Percent Low Birth Weight by Ethnicity
San Francisco, 1998**



Definitions: LOW = 1500 – 2499 grams, VLOW = < 1500 grams.

Source: San Francisco Department of Public Health, AVSS Birth Certificates and Records
Prepared by Population Health, Records and Statistics, August, 1999, Rev September, 1999.

2001 State of the City Public Health Address

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Mitchell H. Katz, M.D.
Director of Health
San Francisco Department of Public Health
April 9, 2001

*The mission of the
San Francisco
Department of Public Health
is to promote and protect
the health of all San Franciscans.*



Mitchell H. Katz, M.D.
Director of Health

2001 STATE OF THE CITY PUBLIC HEALTH ADDRESS

President Ammiano and Members of the San Francisco Board of Supervisors

Thank you for the opportunity to speak to you today on the state of public health in our City. It is an honor to appear before this Board. The Board of Supervisors, along with Mayor Brown, has provided unwavering support and leadership to the Department as it seeks to improve the health status of our residents.

The Board is well aware that dwindling federal and state financial support for health services has significantly compromised our ability to protect and promote health. Although the Board and the Mayor have been generous to the Department in replacing millions of dollars of lost revenue, this replacement in funding has not kept up with the increased cost of services. Medical care inflation has been running significantly higher (4.6%) than the overall inflation in our country, pushing up the cost of both labor and supplies, especially medications. Moreover, there has been an increased demand for services fueled by increases in the number of uninsured in San Francisco and the availability of expensive new therapies (e.g., atypical antipsychotics and hepatitis C treatment). Overall, the Department is being asked to do more with less.

One strategy that we have used successfully to provide more services for less funding is to emphasize community-based services. Community-based services, especially housing with wrap-around mental health and substance abuse services, enables us to care for people who would otherwise need to stay in the hospital. For example, most people with mild or moderate pneumonia do not need to be admitted to the hospital and can be safely treated at home, if they have a home. If they have no home, then we admit them to the hospital. Similarly, people with severe pneumonia must be admitted to the hospital, but can be safely discharged home within 2 to 3 days, if they have a home. The homeless must stay until they are well enough to survive on the streets.

The Health Department is doing all it can to increase housing options for persons who would otherwise need institutionalization. Our direct access to housing program has converted several previously empty or underused single room occupancy hotels into thriving communities. Beginning with the Pacific Bay, we now run the Windsor and the Le'nain. Three more hotels will be opened in the next few months – Broderick (July 2001), Camelot (July 2001) and Star (September 2001). Overall, we are providing housing assistance to 2,500 persons. While we have made great progress in our provision of housing, fires have destroyed several single room occupancy hotels, countless board and care facilities have closed due to poor reimbursement by the State, and we have lost 180 skilled nursing facility beds in San Francisco since 1998 alone. Without appropriate placement options, clients will stay in institutional settings that are more restrictive and more expensive.

Substance abuse is a contributing factor in 17 of the top 20 causes of premature mortality in San Francisco and our methamphetamine, heroin and cocaine emergency room admissions are among the highest in the nation. With the support of the Mayor and Board, expanding substance abuse treatment services continues to be a major initiative of the Department. From 1995-1996 to 1999-2000, our Treatment on Demand Initiative increased treatment slots by 1,901 from 2,963 to 4,864, and we increased contracted substance abuse services client contacts by 36,089 from 140,205 to 176,294. To further improve access to substance abuse treatment services, the Department is developing an Office-based Opiate Addiction Treatment Program. This program will allow primary care physicians like myself to treat addiction in our patients using prescription methadone. My goal is that by this summer I am prescribing methadone, along with my colleagues, at Ward 86 HIV clinic at San Francisco General Hospital.

Mental health treatment is also needed by a substantial portion of the City's indigent population who seek services from the Department. Over the last six years our Community Mental Health Services section has reshaped the delivery of community health mental services. As a result, case management services have increased, homeless outreach services have been augmented and hospital days have been reduced. We have had an almost 40% increase in our caseload from 15,748 to 21,543 between 1993-1994 to 1999-2000.

Another humane way of delivering more services at lower funding levels is to focus on prevention. To the extent that we can prevent illness, we will decrease our costs and more importantly, decrease the burden of disease in our community. Annually, half of the deaths in San Francisco are premature and preventable. Over the last year, the Department augmented community-based and individual based prevention services – such as the African-American Health Initiative, children’s mental health, pedestrian safety, tobacco control and violence prevention – to reduce the incidence of injury and illness.

One cornerstone of the Department’s prevention activities is in the area of HIV/AIDS. As the Board is aware, the number of reported AIDS-related deaths in San Francisco has declined due to the success of the triple combination therapies. San Francisco has seen a more extensive drop than most communities because this Board has also provided enough funding for us to treat all of our patients, regardless of insurance status, with the best available medications. By supporting needle exchange in an era when few counties were brave enough to do so, this Board and Mayor have saved thousands of lives. Currently, we exchange 2 million dirty needles for 2 million clean ones each year. The data show that the effort has paid off in lower rates of sero-conversion among injection drug users. Unfortunately, our prevention efforts have not been as successful for gay and bisexual men. New infections are on the rise. Paradoxically, we believe that the success of HIV treatment has resulted in some people being less safe. To address this issue, the Department and the AIDS Research Institute designed an 11 Point Action Plan to revitalize the HIV prevention programs in the City. My hope is that this plan will help reduce HIV infection rates among men who have sex with men and other persons at-risk of HIV transmission.

Environmental hazards can be important risk factors in the incidence of diseases such as asthma, cancer and heart disease. Accordingly, the Department works with communities to identify and ameliorate environmental factors that could be affecting the health of individuals and neighborhoods. In the last year, the Department received federal funding to conduct environmental assessments of the homes of Department clients with asthma. Findings from the assessments can then be used to develop specific home interventions for asthma sufferers.

As part of the City's ongoing effort to address health concerns, I am pleased to report that earlier this year, the San Francisco Health Commission adopted the Department's strategic plan – *Leading the Way to a Healthier Community*. The Department embarked on a community-wide strategic planning initiative in late 1999 to address changes in demographics, reductions in funding and emerging health needs. The strategic plan identifies community health concerns (e.g., difficulty accessing health services across Department programs) and strategies to address these issues (e.g., improve integration of physical, behavioral, prevention and social services). The strategic plan is a guide to what program initiatives the Department will propose and develop in its annual budgets. The Department's recent proposal to expand health care coverage to uninsured children was cited in the strategic plan. This proposal furthers our goal of achieving universal health care coverage for all San Franciscans. As part of our strategic planning, we are also looking carefully at the infrastructure needs of the Health Department. While our Department's proud tradition is to prioritize services over facilities, one cannot provide quality services in crumbling, seismically unsafe buildings.

The Department fulfills its complex mission through the hard work of a dedicated staff. I would also like to acknowledge the San Francisco Health Commission for their vision and leadership on health issues. The attached written report provides additional information. I look forward to working with you over the next year to fulfill the Department's mission "to protect and promote the health of all San Franciscans."

San Francisco

Department of Public Health

EFFORTS TO ADDRESS

SELECTED PUBLIC HEALTH ISSUES

Public Health Issues

SAN FRANCISCO'S MAJOR PUBLIC HEALTH ISSUES INCLUDE:

- Homelessness and lack of affordable housing
- High incidence of substance abuse/addiction
- High prevalence of mental health problems
- High number of uninsured
- Increasing numbers of HIV infection and those living with AIDS
- High incidence of some communicable diseases
- High number of smokers and those impacted by second-hand smoke
- A high proportion of injuries and deaths that could be reduced by prevention
- Aging population with increasing long-term care needs
- Special health problems faced by children, youth and families
- Environmental health concerns

Leading Causes of Premature Mortality by Sex, San Francisco 1998

This table shows the leading causes of premature death for women and men. In addition, it illustrates the average years of life lost, showing for example that a man dying of HIV infection/AIDS in 1998 died approximately 40 years before he normally would have been expected to die. This table shows the need to focus on efforts to prevent premature mortality.

1998 Rank	Cause of Death	Expected Years of Life Lost	Deaths	Average Expected Years of Life Lost	1997 Rank
MALE					
1	Ischemic heart disease	12,340	839	14.7	1
2	HIV infection/AIDS	6,625	163	40.6	2
3	Drug poisoning, UI	5,207	119	43.8	4
4	Lung cancer	3,525	200	17.6	3
5	Lower resp. (Pneumonia)	2,965	232	12.8	7
6	Cerebrovascular (Stroke)	2,926	203	14.4	5
7	Suicide	2,890	73	39.6	6
8	Homicide	1,986	37	53.7	9
9	Chronic obstr. pulm. disease	1,880	136	13.8	*
10	Inflam/infect/cardiomyop	1,820	74	24.6	*
FEMALE					
1	Ischemic heart disease	8,165	852	9.6	1
2	Cerebrovascular (Stroke)	3,052	297	10.3	2
3	Breast cancer	2,499	115	21.7	3
4	Lung cancer	2,239	138	16.2	4
5	Lower resp. (Pneumonia)	2,192	275	8.0	5
6	Drug poisoning, UI	1,153	24	48.0	7
7	Chronic obstr. pulm. disease	1,074	87	12.3	9
8	Colorectal cancer	997	80	12.5	6
9	Diabetes mellitus	765	58	13.2	8
10	Genito-urinary diseases	764	72	10.6	*

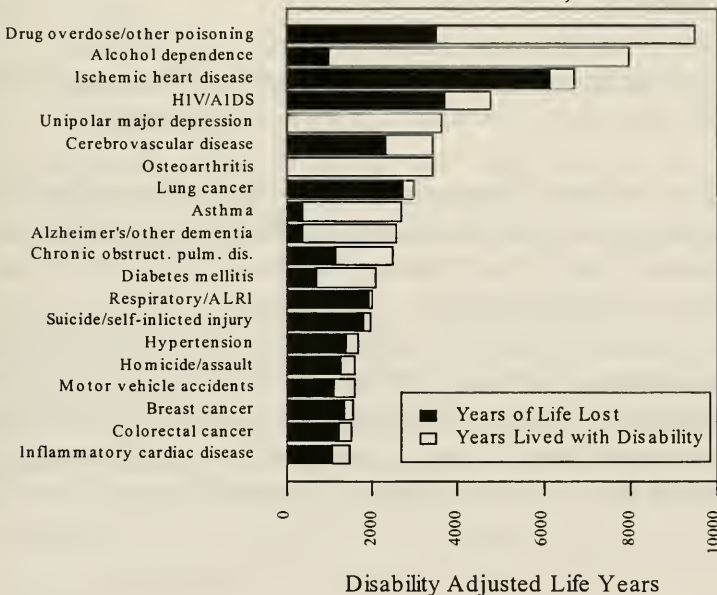
* Not in 1997 top 10 causes of premature mortality

Leading Causes of the Burden of Disease, San Francisco 1998

This graph shows a measure of the overall burden of disease and injury, called disability adjusted life years (DALYs). Since DALYs include years lived with disabilities, as well as years lost to premature mortality, this graph includes an estimate of disabling conditions on the health of the population.

Many of the same conditions cause disability and premature death in San Francisco. However, the impact of substance abuse is seen as greater when also considering the many years of disability caused by drug use and alcohol abuse, the top two conditions on this graph. This graph also shows conditions that disable a significant number of San Francisco residents, but do not result in death, including depression and osteoarthritis.

**Leading Causes of DALYs,
San Francisco, 1998**



Homelessness & Housing

- ❑ Access to affordable housing in San Francisco remains a major public health issue. For individuals with special needs, securing supportive housing that offers an appropriate level of assistance can be very difficult.
- ❑ In the past two years, there have been seven Single Room Occupancy (SRO) hotels lost to fire. One Tenderloin hotel fire in December 2000, displaced 45 residents, killing one and injuring several others. These fires destroy housing for those in the community least able to find alternative housing.
- ❑ At least one-third to one-half of all homeless people suffer from some kind of physical condition that places them at greater risk for serious illness or death.
- ❑ Due to a lack of insurance, poverty and poor nutrition, many of San Francisco's homeless suffer from severe oral conditions.
- ❑ Many of San Francisco's homeless and at-risk Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQQ) youth deal with challenges such mental health issues, substance abuse problems, and risk of sexually transmitted diseases.
- ❑ Some San Francisco General Hospital (SFGH) patients, though medically ready for hospital discharge, need additional assistance. In many cases these patients are homeless and require a safe environment where they can wait for social service interventions or transportation services.

Homelessness & Housing Response

HOUSING ACCESS

- The Department is represented on the Citywide Local Homeless Coordinating Board. In the last year, the Board rewrote the City's Continuum of Care Plan. This draft plan contains the City's philosophy on homeless issues and details specific recommendations for funding and implementation. This plan stresses the need for health and supportive services for this vulnerable population.

IMPROVING SRO CONDITIONS

- The Department chairs the SRO Safety and Stabilization Task Force. This task force is working with SRO owners and tenants to improve conditions. Since the task force began meeting in June 2000, fire mitigation activities have included:
 - working with community-based organizations in the Mission and Chinatown offering fire education, tenancy rights and outreach to SRO tenants;
 - expanding efforts to include the Tenderloin, South of Market and Bayview Hunters Point neighborhoods; and
 - educating and including hotel owners in this process.

ADDRESSING HEALTH NEEDS OF THE HOMELESS

- The Department continues to secure supportive housing sites, with over 200 units completed or in the planning stages. In addition to the Pacific Bay and Windsor hotels, in Fall 2000 the Le'nain Hotel opened providing supportive housing for homeless seniors. Three more sites (Camelot, Star and Broderick) are in the planning stages. Two will provide services to chronically homeless people with disabilities and one will offer twenty-four hour nursing care for homeless persons with medically complex conditions.

Homelessness & Housing Response

- The Department added 16 units of hotel-based respite care where patients diagnosed with medical and psychiatric illness receive care through a multidisciplinary team of health care providers. These individuals are then placed in programs or facilities that can provide longer-term assistance, are helped to find permanent housing, or are reunited with their families.

ADDRESSING ORAL HEALTH NEEDS OF THE HOMELESS

- The Tom Waddell Health Center and the Department's Dental Services Unit developed a program to provide oral health care and outreach to homeless and HIV infected people.

SERVICES FOR LGBTQ HOMELESS YOUTH

- The Department contracted with the Ark of Refuge to operate a transitional housing program for LGBTQ youth. The Ark House opened in March 2001 and serves San Francisco's LGBTQ young adults who are either currently homeless or at risk of becoming homeless. Services include case management, employment counseling, mental health support, substance abuse prevention, primary care and money management.

SFGH DISCHARGE LOUNGE

- SFGH's new discharge lounge opened in December 2000. It serves patients waiting for transportation and/or social service assistance.

Substance Abuse

- San Francisco County has the third highest rate of drug-related deaths, with a rate of 20.4 per 100,000 people in 1999. The State rate is 9.1 and the National Objective for 2010 is 1.0.¹
- In a typical month in San Francisco, there are approximately 19 deaths related to heroin, cocaine or speed², and 5 additional deaths of homeless individuals related to substance abuse.
- Heroin continues to be San Francisco's number one drug problem with an estimated 17,100 injection drug users (IDUs) in 2000.³ Currently, only 2,554 of these heroin users have access to methadone maintenance treatment.
- In a typical month in San Francisco, 21% of students ride in a vehicle with an intoxicated driver, and there are 54 injuries (including 1 or 2 deaths) due to drinking drivers.⁴
- For some people who abuse substances or have unsafe sex, abstinence-based programs alone may not be successful. As a result, the Department must develop multiple strategies to improve health status among these residents.

¹ CA Dept. of Health Services, County Health Status Profiles, April 2001

² Chief Medical Examiner, Annual Report, 1999-00

³ HIV Consensus Report, 2000

⁴ SF Unified School District, 1999 Youth Risk Behavior Survey

Substance Abuse Response

PREVENTING DEATHS FROM OVERDOSE

- In order to reduce deaths from heroin overdoses, the Department sponsored a project that trains inmates at City jails how to perform rescue breathing and CPR. This teaches individuals the skills to save a life in case of drug overdose.

ACCESS TO SUBSTANCE ABUSE TREATMENT PROGRAMS

- San Francisco's Treatment on Demand Initiative continues to improve access to substance abuse programs. Treatment on Demand Initiative outcomes from FY 1995-1996 to FY 1999-2000 include:
 - An increase in the number of substance abuse client contacts that were contracted for by 36,089 (from 140,205 to 176,294).
 - An increase in the number of direct substance abuse treatment slots by 1,901 (from 2,963 to 4,864).
 - A decrease in the number of clients waiting for treatment at the end of each month (approximately 1,200 prior to Treatment on Demand to 900 in June 2000).
- To increase access to opiate addiction treatment using methadone or other medications, the Department is developing the Office-based Opiate Addiction Treatment Program (OBOAT). This program will allow physicians full discretion to treat addiction through prescription methadone or similar medication. OBOAT is currently in the process of a feasibility study and is targeting a pilot project start in the summer of 2001.

REDUCING ALCOHOL ABUSE

- In the last year, staff from San Francisco General Hospital's Emergency Department assisted the Police Department with the *Every 15 Minutes* program at three schools. This successful two-day program involves the entire school in a mock event designed to demonstrate the potential consequences of drinking alcohol and driving.

Substance Abuse Response

HARM REDUCTION APPROACHES

- The Health Commission passed a resolution, formally adopting harm reduction as another treatment model for substance abuse, STD and HIV. In using a harm reduction approach, staff recognize that some people will continue to abuse substances and practice unsafe sex. Staff help clients understand the risks associated with their behaviors, and encourage them to make choices which will reduce harm to themselves, their family and their communities.
- The Department hosted the third “Bridging the Gap” conference since 1997, focusing on the integration of harm reduction and traditional substance abuse service strategies. There were over 50 local, national and international speakers at the two-day event, and over 500 attendees.

Mental Health

- Approximately 12,000 seriously emotionally disturbed children and youth and 32,000 seriously mentally ill adults live in San Francisco.
- An increasing number of San Francisco residents receive services through the Community Mental Health Services (CMHS). However, some individuals with significant mental health problems are not receiving needed treatment.¹
- As many as 37% of San Francisco's homeless population have a mental illness.² Of these, approximately half were receiving on-going mental health treatment in FY 1999-2000.
- Residents of Bayview Hunters Point are disproportionately affected by violence and the potential of violence in their neighborhood, creating a need for specialized mental health interventions and outreach.
- In November 2000, there were 2,466 children in Foster Care in San Francisco, 65% of these children are African-American.³ These children and their families have a special need for supportive and mental health services.

¹ California Mental Health Master Plan (Draft), California Mental Health Planning Council, Sacramento, CA, 2000.

² Urban Institute/U.S. Housing and Urban Development Report December, 1999.

³ SF Dept. of Human Services, Foster Care Quarterly Report, November 2000.

Mental Health Response

SERVING AN EXPANDING CLIENT BASE

- Community Mental Health Services (CMHS) had nearly a 40% caseload increase from 15,758 in FY 1993-94 to 21,543 in FY 1999-2000.
- CMHS increased the number of Medi-Cal beneficiaries served from 10% to 13% between FY 1992-93 and FY 1999-2000. The increase for Foster Care has been from 20% to 40% and disabled Medi-Cal recipients 26% to 37%. CMHS increased the number of uninsured clients by 20% between FY 1996-97 and FY 1999-2000.
- In FY 1999-2000, the Department increased the number of long-term supportive housing beds by 145, increasing the availability of non-hospital beds and services offered in the community.

OUTREACH FOR EMOTIONALLY DISTURBED CHILDREN AND SERIOUSLY MENTALLY ILL ADULTS

- The High Quality Child Care Mental Health Initiative provides on-site service to infants and pre-school age children and their families, at more than 60 child care centers and 100 family child care homes.
- Through Project Impact, youth involved with the juvenile justice system are assessed for mental health needs at the Youth Guidance Center. Through the on-site assessment service, service linkage can be made to outpatient, day treatment, intensive case management, mobile support, and community alliance services.

MENTAL HEALTH SERVICES FOR THE HOMELESS

- In 1999-2000, CMHS developed a project making it possible to serve an additional 120 homeless, seriously mentally ill adults who were not linked with community-based mental health services.

Mental Health Response

MENTAL HEALTH OUTREACH IN BAYVIEW HUNTERS POINT

- The Department is in the beginning stages of working with residents of Bayview Hunters Point to address the effects of violence in their community. Quarterly community forums have begun, allowing for increased mental health interventions, sharing information about resources, and counseling individuals on ways to deal with stress.

SERVICES FOR CHILDREN IN OUT-OF-HOME PLACEMENTS

- The Family Mosaic Project (FMP) continues to have highly positive outcomes. FMP serves out-of-home placement children and youth, coming from underserved communities, with the majority of clients being African-American. As a result of the program, between 1996 and 2000 the number of youth who required inpatient mental health care and the number of days of hospitalization were dramatically lower than the countywide data. Of the 63 clients who had criminal activity in the year before FMP participation, only 10% committed a crime in the year following the program.

The Uninsured

- While the number of uninsured has declined in California, there are still an estimated 135,000 San Franciscans lacking health care coverage. Many of these uninsured residents are low-income workers and people of color.
- Of those San Franciscans who are uninsured, over 9,200 are children and youth. Many of these children are eligible for publicly-funded health insurance programs such as Medi-Cal or Healthy Families.
- San Francisco General Hospital (SFGH) patients with prescriptions frequently encountered long waits at SFGH's pharmacy due to high demand. Most of these patients, lacking health insurance, could not access services through other pharmacies in San Francisco.
- In many cases, San Franciscans who lack health care coverage have a more difficult time accessing needed services than insured residents.
- Uninsured individuals seek health care from a variety of providers. Essential medical information may not be available to providers making treatment decisions and coordinating care for these patients. This situation can create barriers when seeking appropriate care.

The Uninsured Response

EXPANDING HEALTH CARE COVERAGE

- Under the direction of Mayor Brown, the Department is working to expand health care coverage to certain persons working on City contracts and leased property.

HEALTH COVERAGE FOR CHILDREN

- The Department's proposal to cover children through a City program received approval from the Health Commission in January 2001. The objectives of this program are to:
 - insure low-income San Francisco children who are not eligible for existing publicly-funded programs; and
 - minimize barriers for children enrolling in existing state/federally-funded programs.

ENROLLING ELIGIBLE CHILDREN IN MEDI-CAL AND HEALTHY FAMILIES

- The Department, in participation with the Bringing Up Healthy Kids (BUHK) Coalition, actively promotes and advocates for insurance coverage for the City's children and youth, and works to enroll all eligible children in the appropriate public programs. BUHK completed its second year of conducting successful school-based outreach in collaboration with the San Francisco Unified School District and community-based agencies. Through this effort, applications were submitted for 697 children from March 2000 through February 2001.

INCREASING PHARMACY OPTIONS FOR SFGH PATIENTS

- In an effort to improve pharmacy services, the Department now offers prescription services to SFGH patients through independent and chain pharmacies. This effort has improved access to medications and has reduced waiting times at the pharmacy at SFGH.

The Uninsured Response

IMPROVING ACCESS TO HEALTH CARE

- The Department has made significant effort to remove barriers for uninsured individuals attempting to access health care, specifically preventive services like breast and cervical cancer screening. Breast and Cervical Cancer Services (BCCS) outreach efforts included the following:
 - held two community town hall breast cancer forums (following the event, a women's clinic provided exams for attendees);
 - developed a patient guide to the Breast Clinic at San Francisco General Hospital in Spanish and English;
 - created a women's clinic at SAGE to serve women involved in the sex industry; and
 - facilitated women's health education classes at the County jails.

REMOVING BARRIERS AND IMPROVING CARE

- The Department's Community Health Network (CHN) partnered with the San Francisco Community Clinic Consortium (SFCCC) to increase access and improve the quality of care to their patients, many of whom are uninsured. The plan has the following goals:
 - enhance care by installing an Electronic Medical Record (EMR) system allowing SFCCC's nine health centers and CHN to share information;
 - reduce barriers to care through the creation of a single patient eligibility system;
 - maximize community-based primary care through an improved clinical referral system and coordinated care for patients receiving specialty care; and
 - address the increasing demand for mental health services by implementing programs in the primary care setting.

HIV & AIDS

- The rate of new infections among Men who have Sex with Men (MSM) is increasing in San Francisco. Preliminary estimates report that the rate of HIV infection among MSMs in 1997 was 1%, rising to 2.2% in 2001 (748 new infections projected for this year). 2001 rates of HIV infection among MSMs who also inject drugs are projected to be over twice the 1997 rate.¹
- The increase in HIV incidence, coupled with decreases in AIDS incidence and deaths, have increased the number of persons living with HIV/AIDS who are in need of health care and social services, as well as safe sex education.
- The success of highly active antiretroviral therapies (HAART) on reducing HIV-related morbidity and mortality may contribute to a recent increase in sexual risk behaviors among MSMs, the group most severely affected by HIV infection in San Francisco.
- On any given day there are approximately 100 known HIV-infected individuals in the San Francisco County jail. Nationally, the AIDS case rate is six times higher among those incarcerated.

¹ HIV Consensus Panel Report, January 2001.

HIV & AIDS Response

ACTION PLAN FOR PREVENTION

The Department and the AIDS Research Institute designed an *11 Point Action Plan* to revitalize HIV prevention programs in the City.

- **OWNERSHIP.**

Take ownership of the epidemic, implementing culturally-specific, community-driven responses. Prevention is not done to a community, but by and with a community.

- **CONDOMS FOR HIV POSITIVE TOPS WITH HIV NEGATIVE BOTTOMS.** Assume responsibility.

- **CONDOMS FOR HIV NEGATIVE BOTTOMS WITH HIV POSITIVE TOPS.** Assume responsibility.

- **KNOW YOUR CURRENT HIV STATUS.**

Get HIV tested every six months if you've had risky sex or needle use. Seek care if you are HIV positive.

- **PREVENTION FOR POSITIVES.**

Develop and expand HIV prevention programs that are designed by and for HIV positive individuals.

- **ERADICATE BACTERIAL STDS IN GAY MEN.** Rectal gonorrhea, syphilis, chlamydia.

- **RECOVERY.**

Expand drug treatment. Mature our substance abuse services to address real life issues facing gay men such as the relationship between speed use, Viagra, and unprotected sex.

- **COUNSEL.**

Rebuild the network and services for mental health and wellness.

- **POSITIVE CARE.**

Get more HIV positive people into care, onto appropriate anti-viral treatments, on better treatment regimens, improve adherence and provide individually tailored counseling and care.

- **REALITY CHECK.**

It remains a fundamental truth that it is better to remain HIV negative. If you are HIV negative, you should stay that way!

- **GAY MEN'S HEALTH MATTERS.**

It is important that HIV prevention be nested within a broader health agenda for the community.

HIV & AIDS Response

IMPROVING ACCESS TO SERVICES

- The Department partnered in the creation of two Action Point programs. These drop-in programs, located in South of Market and Bayview Hunters Point, serve homeless or marginally housed, HIV-positive individuals helping them adhere to complicated medication schedules. Additionally, the Bayview Action Point provides 50 methadone maintenance slots.

PREVENTION STRATEGIES

- The Department works with Better World Advertising to produce HIV/AIDS prevention social marketing campaign for HIV-positive gay/bisexual men and transgenders in San Francisco. The campaign consists of a website (www.hivstopswithme.org), newspaper ads, postcards and a television commercial.
- The Department created the Fund for Innovation to support new, creative strategies to prevent HIV:
 - The Stop AIDS Project's (www.stopaids.org) web-based outreach project to reach men who meet other men on the Internet.
 - The Tenderloin AIDS Resource Center to fund a peer-resource and day drop-in center in one of the City's hardest hit areas.
 - The AIDS Health Project's program added STD testing and treatment for their clients.
- Continued services through the Department's needle exchange programs have resulted in a decrease in HIV infection for intravenous drug users.

HIV/AIDS SERVICES IN JAIL

- The Forensic AIDS Project (FAP) of Jail Health Services began a three-year demonstration project for HIV-infected incarcerated individuals. The San Francisco County Jail has enhanced current FAP and Tenderloin Care services through the addition of individual substance abuse counseling, groups for HIV positive inmates, additional case management staff, and transitional housing. The objective is to reduce recidivism while encouraging adherence and healthier lifestyles.

Communicable Diseases

- Both the number of cases and rates increased for all Sexually Transmitted Diseases (STDs) in San Francisco in 2000 (including chlamydia, gonorrhea, and syphilis), compared to 1999.
- According to preliminary reports, early syphilis cases rose from 44 cases in 1999 to 71 cases in 2000 (61% increase).
- In San Francisco cases among men who have sex with men (MSM) accounted for 75% of the syphilis cases and 41% reported being HIV-positive. The Internet plays a key role in developing sexual networks among MSMs; consequently the Department receives continued reports of syphilis among gay men associated with Internet chatrooms.
- Due to two decades of a strong focus on prevention and treatment of tuberculosis through targeted interventions, San Francisco saw TB rates at an all-time low in 2000. But the disease infects San Franciscans at a rate over twice that of other Californians and at three times the national rate.

Communicable Diseases Response

NEW APPROACHES FOR TESTING AND TREATMENT

- During the summer of 2000, the STD Program launched a pilot project to test the feasibility of postal STD screening. Urine cups and mailers were available at two locations in the Castro and individuals could pick them up and mail the specimen directly to the Department's lab for processing. Approximately 100 of 400 kits were mailed to the lab and 34 new infections were identified.
- STD education and urine screening for gonorrhea and chlamydia was offered at the CATS nightclub. This activity generated local and national publicity and proved that it is feasible to offer this type of service in this type of venue.

SYPHILIS RESPONSE

- The STD Program established a syphilis rapid response team to immediately investigate all cases of primary, secondary and early latent syphilis.

UTILIZING THE INTERNET FOR STD EDUCATION AND OUTREACH

- The STD Program implemented monthly one-hour live chat sessions available through Gay.com, a web site popular with MSMs. Recently, the STD Program facilitated a discussion on negotiating safer sex. This has been an excellent way to provide general STD information and prevention strategies to a variety of individuals.

CONTROLLING TUBERCULOSIS

- It is estimated that 30-50% of all foreign born newcomers arriving in San Francisco are infected with Tuberculosis. A community treatment site opened in 2000 at the Chinatown Public Health Center to test and treat individuals in a community of high incidence.
- Intake medical screening and intense post-admission screening through Jail Health Services has greatly reduced the severity of exposure for those in the jail system.

Tobacco

- In San Francisco smokers include:
 - 9% of middle school students,
 - 19% of high school students,
 - 17.7% of adults (based on 1998 data).
- A random survey of San Francisco stores in 2000 found that 8.2% sold tobacco to minors, compared to 15.7% in 1999.
- Youth exposure to outdoor tobacco advertising was reduced. Based on random surveys, compliance with the outdoor tobacco ad ban increased from 41.3% in 1998 to 73.5% in 2000.
- A random survey in 2000 found 95.9% of restaurant bars in compliance with the smokefree bar law while 58.1% of stand-alone bars were in compliance. In 1999, 91.4% of restaurant bars and 39.7% of stand-alone bars were in compliance.

Tobacco Response

SMOKING CESSATION

- During 2000, 153 smokers enrolled in the Department's Stop Smoking classes. Among participants who completed both pre-tests and post-tests, 54% quit.

YOUTH AND TOBACCO

- The Department conducted extensive research on effective tobacco prevention media messages. Based on research findings, existing ads were selected and five new ones produced with a mix of messages found to be most effective in reaching youth. Production and media placement were made possible with one-time Mangini tobacco settlement funds.
- The Department assured that laws designed to reduce youth smoking were being actively enforced. Active enforcement of illegal tobacco sales to minors by the Police Department and the local ordinance banning outdoor tobacco ads by the Department of Consumer Protection is funded from Tobacco Master Settlement funds.

SMOKE FREE BAR LAW

- In response to complaints, five bar owners were cited for illegal smoking in bars.
- The Department collaborated with the City Attorney's Office to address flagrant non-compliance with the smoke-free bar law. Lawsuits were filed against six bar owners based on unfair business practices and subsequently settled.
- Educational letters were sent to bar owners following complaints informing them of their duties and legal liabilities.

Injury & Illness Prevention

- Last year in San Francisco there were more than 7,000 motor vehicle injuries. A disproportionately large share of vehicular fatalities are pedestrians.
- Homicides in San Francisco are decreasing, with a decline in firearm homicides. However, San Francisco's 1999 death rate for homicide is 6.5 per 100,000 population (higher than the state average) and over twice as high as the National Objective for 2010 of 3.0.¹
- While the number of refugees with serious health needs is declining, there is still a significant number who need assistance. Refugee groups tend to have higher rates of smoking, tuberculosis, mental health problems and supportive housing needs than other immigrant groups.
- Persons over age 65 are at increased risk for injury-related deaths and hospitalizations. While those over 65 represent 15% of the San Francisco population, they represent approximately 45% of all injury hospitalizations and 21% of all injury-related deaths.

¹ CA Dept. of Health Services, County Health Status Profiles, April 2001.

Injury & Illness Prevention Response

INCREASING PEDESTRIAN SAFETY

- The Department is working with community-based organizations to develop a strategic plan to reduce pedestrian injuries.
- The San Francisco Pedestrian Safety Project brings together City departments to develop a basis for understanding and evaluating pedestrian safety issues. Projects include a Community Capacity Building effort and mini-grants to community groups.

VIOLENCE PREVENTION IN THE COMMUNITY

- In February 2001, the Violence Prevention Network (VPN) released the Road Map for Preventing Violence in San Francisco. This document will help communities identify issues and take action to prevent violence.
- The VPN supports numerous Community Action Teams working to:
 - reduce access to firearms;
 - educate communities in media literacy; and
 - educate about and prevent domestic and dating violence for adults and teens.

ADDRESSING THE HEALTH NEEDS OF REFUGEES

- The Newcomers Health Program is implementing Refugee Community Health Outreach for Bosnian refugees focusing on community building, health education and leadership development.
- The SUNSET Russian Tobacco Education Program conducts culturally appropriate community education, media outreach, and Russian language secondhand smoke and tobacco cessation workshops.

PREVENTING INJURIES FOR SENIORS

- The Community and Home Injury Prevention Project for Seniors (CHIPPS) held Injury Prevention trainings for 33 agencies in 2000. Home safety assessments were provided to 39 seniors; 28 seniors received free home safety repairs and modifications.

Long Term Care

- San Francisco's population of older individuals is increasing. Many of these individuals will require long-term care. By 2020:
 - San Franciscans 65 and over will increase from 116,080 (15% of total SF population) to 181,981 (23.4% of total SF population).
 - San Franciscans 85 and over will increase 17,718 (2.3% of total SF population) to 26,832 (3.4% of total SF population).¹
- Elderly and disabled persons prefer to receive long-term care services either in their homes or in community settings. However, limited access and knowledge of health care options can result in some receiving care in hospitals and nursing homes.

¹ State Department of Finance, Census Figures, April 1990.

Long Term Care Response

MEETING THE NEEDS OF AN INCREASING OLDER ADULT POPULATION

- The Department of Aging and Adult Services is partnering with the Department to develop, “SF Get Care: A Web-Based Information System for Integrating Community Based Long-Term Care Services in San Francisco.” This innovative internet project will increase access to community-based long term care (LTC) services, ensure appropriate placement and enhance overall LTC system efficiency and quality of care.

LONG TERM CARE IN THE COMMUNITY

- Laguna Honda Hospital and Rehabilitation Center (LHHRC) implemented the “Short-Term Care Program: Expediting Reentry to the Community.” Short-Term Care is a program providing services to individuals who can be discharged within 90 days, utilizing rehabilitation interventions and discharge planning.

PLANNING A NEW LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER

- Since voter approval of Proposition A (to replace LHHRC and build assisted living units), the project has done the following:
 - Selected an architect: Anshen and Allen/Gordon Chong & Partners
 - Completed Phase I environmental testing
 - Completed functional and space programming for the new building
 - Established the Community Advisory Group
 - Issued the Initial Study in February 2001 for public review (part of the Environmental Impact Report process)
 - Selected construction management consultants
- The project consists of 1,200 skilled nursing beds and 140 assisted living beds.

Children, Youth & Families

- San Francisco's overall infant mortality rate was 4.4 per 1,000 live births, meeting the National Objective for 2010. Yet, the African-American death rate for infants from birth to one year old in 1999 was 11.9 (almost three times the overall rate).¹
- In 1999, 83.8% of San Francisco mothers initiated breastfeeding, better than the California average of 79.9% and the National Objective of 75%.²
- In San Francisco, over 20% of children and youth under 18 years of age live in poverty.³ Health outcomes and access to health care are strongly linked to income.

¹ CA Dept. of Health Services, County Health Status Profiles, April 2001

² Ibid

³ Economic Census, 1997

Children, Youth & Families Response

IMPROVING INFANT MORTALITY OUTCOMES IN AFRICAN-AMERICAN COMMUNITIES

- Outcome data show zero infant deaths for families enrolled in the Department's Black Infant Health and "Sistah Sistah" programs, offering African-American mothers home visits in Bayview Hunters Point, Oceanview-Merced Heights-Ingleside, Visitacion Valley, and the Western Addition. Because of this demonstrated success, the Maternal and Child Health section of the Department is expanding both programs.

BREASTFEEDING SUPPORT

- The San Francisco Breastfeeding Coalition's mission is to improve the health of the community by promoting breastfeeding as the cultural norm. The Coalition produced the Lactation Services Directory 2000.
- The Women's Health Center at SFGH opened a Women's Breastfeeding Center staffed by a team of lactation experts including nutritionists, nurses and health workers. The Center provides lactation counseling in seven different languages and facilitates a Breastfeeding Support Group.

HEALTHCARE OUTREACH TO CHILDREN

- The new Childcare Health Project targets low-income children, providing health and safety consultation services to the childcare community. Through this program, children are helped to achieve better health in their formative years. The Childcare Health Project is expanding in 2001 with additional nurses, as well as a nutritionist, dental services and hearing services.

Environmental Health

- San Francisco's asthma hospitalization rates are among the highest in the State. Environmental triggers in the home may be partially responsible for this excess.
- Active local enforcement is still necessary in San Francisco to ensure compliance with our environmental protection laws.
- Public health interventions are acknowledged to be most successful when done in collaboration with all communities affected.

Environmental Health Response

ASSESSING INDOOR ENVIRONMENTS

- The Department received federal funding to provide environmental assessments of homes for Community Health Network clients with asthma, and will evaluate the effectiveness of this program.

ASSURING APPROPRIATE DISPOSAL OF HAZARDOUS WASTE

- Environmental Health Section (EHS) staff identified and halted a property owner who was illegally disposing of contaminated medical waste with ordinary garbage. This action resulted in fines and penalties of over \$1 million.

ADDRESSING PUBLIC HEALTH NUISANCES

- EHS, in collaboration with San Francisco League of Urban Gardeners (SLUG) and the Department of Public Works instituted more aggressive rodent monitoring and abatement activities in Chinatown, Fisherman's Wharf, and downtown areas. In addition, in the last fiscal year EHS responded to 2,000 complaints, including vermin and pigeon infestation, overgrown vegetation, and waste disposal.

LISTENING TO COMMUNITY ENVIRONMENTAL CONCERNS

- The EHS staff regularly attend neighborhood meetings to better understand and strategize around community environmental concerns. These interactions have lead to several collaborative responses in the past year:
 - training community residents on sanitation and operational requirements for their neighborhood businesses;
 - partnering with San Francisco League of Urban Gardeners to identify barriers to healthy nutrition;
 - working with the Navy and Bayview Hunters Point residents to revise the Shipyard's emergency response plan; and
 - reviewing the health impacts of major new land uses especially in the Southeast sectors of the city;

San Francisco

Department of Public Health

STRATEGIC PLANNING INITIATIVE

The Strategic Planning Process

THE PURPOSE OF THE STRATEGIC PLAN

- The Department undertook the strategic planning process in order to:
 - Respond to San Francisco's changing demographic and health needs
 - Plan with the community for health improvement
 - Strengthen prevention efforts
 - Identify program priorities to maximize the effectiveness of limited resources
 - Respond to funding needs

HOW THE PLAN WAS CREATED

- Committees (with representatives from staff, advocates, consumers and providers) were formed and began meeting in October 1999. Committees included:
 - Steering Committee
 - Finance Subcommittee
 - Population and Programs Subcommittee
- In 2000, the Department held 52 town hall meetings with approximately 1,400 attendees. Additionally, the public could access information on the Department's Internet site, which was regularly updated throughout the process. Both the full Strategic Plan and the Executive Summary are posted on the Department's website.

THE FINAL PLAN

- The San Francisco Health Commission adopted Resolution 3-01 endorsing the strategic plan on January 16, 2001.
- The Department of Public Health is responsible for regularly reporting to the Health Commission on its progress.
- The Health Commission will provide oversight and approval of all strategic plan recommendations resulting from the strategic planning initiative.

The Strategic Plan

- The Strategic Plan has four goals over the next three years:
 - Goal 1: San Franciscans have access to the health services they need, while the Department emphasizes services to its target populations.
 - Goal 2: Disease and injury are prevented.
 - Goal 3: Services, programs, and facilities are cost-effective and resources are maximized.
 - Goal 4: Partnerships with communities are created and sustained to assess, develop, implement and advocate for health funding, policies, programs, and services.

OVERALL DIRECTION

- The Strategic Plan can help to ensure that services meet the community's needs. The plan recommends, among other things, that the Department:
 - Expand health insurance coverage to uninsured residents.
 - Improve coordination of medical care, prevention, mental health, substance abuse, housing, and social services.
 - Ensure that all residents have access to high quality health care.
 - Continue to provide services in the language of patients and in ways that respect their cultural beliefs.
 - Expand and emphasize community-based care (e.g., clinics, home care) instead of care in hospitals or nursing homes.
 - Provide services to those most in need and to those who have no other options to receive services.
 - Emphasize prevention of illness and injury.

The Strategic Plan

IMPLEMENTATION

- The Department is developing an implementation plan and will provide regular reports to the Health Commission. The Health Commission will hear its first report on implementing the strategic plan in April 2001.
- The Department communicated the final plan to the public at eleven town hall meetings held in February and March 2001. The Department will continue to inform staff of the strategic plan through meetings in Spring 2001.

San Francisco

Department of Public Health

REBUILDING

SAN FRANCISCO GENERAL HOSPITAL

SFGH Rebuild

BACKGROUND

- California legislation, SB 1953 (Alquist) and SB 1801 (Speier), requires that existing acute care hospitals in California either be seismically upgraded to progressively higher standards, or rebuilt, to minimize the risk to life and property in the event of a major earthquake.
- The regulations require that San Francisco evaluate San Francisco General Hospital (SFGH) for seismic deficiencies and develop a compliance plan that defines retrofit repairs or new construction.
- It was determined that while the existing SFGH Main Hospital building may continue to be used for ambulatory care clinics, outpatient diagnostic services, acute psychiatry, skilled nursing facility, and program offices, as of 2008 it may no longer be used for general acute care.
- After reviewing various options, the Mayor and Health Commission (Resolution #1-01) recommended that the City pursue plans for rebuilding SFGH.

PLANNING PROCESS

- Three Subcommittees met from January to March 2001 to review program, finance, and technical issues.
- The eighty Committee members included representatives from business and civic groups, the community, health care professionals, labor unions, neighbors, community agencies and consumers.
- The Committees were charged with making recommendations on:
 - program components, size and adjacencies;
 - possible funding sources at state and federal levels
 - projected budget and finance mechanisms;
 - code and compliance with seismic regulations;
 - general parameters for overall campus planning; and
 - formalizing recommendations to the Health Commission.

SFGH Rebuild

GUIDING PRINCIPLES

- ❑ Single Standard of Quality Care – SFGH seeks to provide a single standard within the Community Health Network (CHN) and the Department, as well as ensuring that the service quality meets community standards.
- ❑ Integrated Delivery System (IDS) – The coordination of services and clinical information throughout the continuum of care is essential for providing quality services to a safety-net population.
- ❑ Academic Affiliation – The Department of Public Health and the community benefits from, and is committed to continuing, its collaboration with the University of California at San Francisco (UCSF) Schools of Medicine, Pharmacy, Dentistry and Nursing.
- ❑ Collaboration – Planning and problem solving are enhanced when providers, staff, patients and community are included in the process.
- ❑ Public Accountability – The residents of San Francisco hold the Department accountable for the level of services and the quality of care provided.

ASSUMPTIONS

- ❑ SFGH will continue as a Level I Trauma Center.
- ❑ SFGH will continue to function as a referral center for safety net providers.
- ❑ SFGH will continue to maintain an academic affiliation with UCSF.
- ❑ Though the City is committed to caring for the incarcerated and indigent populations, the patient base should be expanded to help support a general acute hospital both programmatically and financially.

RECOMMENDATIONS OF THE SFGH REBUILD PLANNING COMMITTEE

- ❑ The recommendation is to wait until 2002 to bring a bond measure before the voters. This will provide additional time to build on the SFGH Institutional Master Plan, address State legislative changes, explore collaborative efforts with UCSF and elicit further community input.

San Francisco

Department of Public Health

CITY/COUNTY RESPONSES TO
STATE MANDATES

Local Strategies-

Implementing State Mandates

- Proposition 215, Compassionate Use Act of 1996, allows Californians to obtain and use marijuana for medicinal purposes. Implementing the proposition required San Francisco to develop a procedure for identifying residents who qualify for medical cannabis.
- Many substance abusers commit crimes to support their substance abuse habits. Some of these residents end up in jail, as opposed to receiving treatment. State Proposition 36, the Substance Abuse and Crime Prevention Act of 2000, now requires counties to provide treatment for substance abusers who commit certain non-violent drug possession offenses. The California Department of Justice reported 10,679 drug-related arrests in San Francisco in 1999. The San Francisco District Attorney's Office and the San Francisco Sheriff's Office estimate that between 1,200 and 2,400 San Franciscans will qualify for drug abuse treatment under Prop 36 each year.

Local Strategies-

Implementing State Mandates

MEDICAL CANNABIS VOLUNTARY IDENTIFICATION CARD PROGRAM

- With the support of health care providers, city agencies, community-based organizations, consumers and the public, the Department implemented the Medical Cannabis Voluntary Identification Card Program in July 2000. With a \$25 fee and a doctor's statement, San Francisco residents can obtain an ID card issued by the Department showing that they qualify as medical cannabis users under Prop 215. Primary caregivers can also obtain ID cards to satisfy law enforcement inquiries about their possession of cannabis under Prop 215. From July 2000 through February 2001, 1,110 cards were issued.

EXPANDING DRUG TREATMENT OPTIONS UNDER PROPOSITION 36

- Several city agencies – Board of Supervisors, Public Health, District Attorney, Sheriff, Probation, Courts – have worked collaboratively to respond to Proposition 36. The Board of Supervisors designated the Department of Public Health as the lead agency for this initiative. San Francisco will receive \$2.3 million in State funds this FY 2000-01 to expand treatment services to these residents. A Prop 36 Steering Committee was created to develop San Francisco's county plan for Proposition 36 funding. The first meeting was held in February 2001 and all meetings are open to the public.

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Mitchell H. Katz, M.D.
Director of Health
San Francisco Department of Public Health
April 8, 2002

*The mission of the
San Francisco
Department of Public Health
is to promote and protect
the health of all San Franciscans.*

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2002 STATE OF THE CITY PUBLIC HEALTH ADDRESS

President Ammiano and Members of the San Francisco Board of Supervisors, thank you for the opportunity to speak to you today on the state of public health in our City. It is an honor to appear before you. The Board of Supervisors, along with Mayor Brown, has provided unwavering support and leadership to the Department as it seeks to fulfill our mission: to protect and promote the health of all San Franciscans.

This is a critical time for our nation. The horrible tragedy of September 11, 2001, coupled with the anthrax exposures and threats, challenged our strength and resolve. These events also underscored the importance of a competent, prepared local Department of Public Health. Although San Francisco was spared an actual attack, we were not spared from hundreds of potential threats. With our co-responders the Police and Fire Department, we responded to all of these threats with our Environmental Health Toxics Unit, our public health laboratory, and our team of epidemiologists.

Although we have not had a recent threat, we have been preparing for future attacks. Our Emergency Medical Service Agency and Communicable Disease Section have been working closely with the other hospitals in San Francisco to be prepared to respond to a large scale attack: we have protocols ready for how to deal with the horror of multiple casualties and the need for decontamination facilities; we have antibiotics stockpiled; and implementation plans for staff mobilization. I sincerely hope all of this work is for naught; that we are never called on to activate our protocols. However, we cannot risk being unprepared. We cannot wait until an actual attack to figure out how to manage it. The plans are developed; we are currently practicing and improving them.

Of course, while we are planning for emergencies, our daily work continues. We are experiencing an increasing demand for an expanded array of health services, as well as increases in the number of indigent and uninsured clients. New medical treatments and tests are available, which physicians like myself who trained in the 80's would not even have dreamed of. These treatments allow us to prolong life, decrease suffering, improve function, but they achieve these goals at tremendous cost.

I am proud to say that we are still able to offer indigent, uninsured patients top quality medical care—as good or better than the care any insured person would receive at any hospital in the City—but our waits for this care are growing longer and longer; our resources are insufficient to meet the demand in a timely way. To maintain our current level of services, in the face of increased demand, we must reduce costly inpatient care by increasing the use of less expensive, more integrated community care and promoting prevention initiatives.

The cornerstone of our efforts to promote community-based care is the Department's Office of Housing and Urban Health (HUH), which has expanded community options to institutional care by providing housing with services, known as supportive housing. Supportive housing provides services such as on-site case management, individual and group mental health counseling, vocational workshops, substance abuse counseling, medical services and transportation to enable previously homeless persons, persons with disabilities, those struggling with mental illness and substance use, to successfully live independently. In 2001, we opened our third master-leased single room occupancy hotel (SRO), the LeNain Hotel, a 91-unit SRO for homeless seniors. We also opened the Broderick House, a 34-bed residential care residential facility this year. Of the original tenants of the Broderick, nine came from SFGH, 12 from the Mental Health Rehabilitation Facility, seven from Laguna

Honda Hospital, and six were referred from community-based organizations. This proves that the Health Department can successfully move people from an institutional setting to a community-based setting, saving the City thousands of dollars and offering a less restrictive environment for our clients. During this year, HUH also helped develop Autumn Glow, a 15-bed residential care facility for elderly people with Alzheimer's and other forms of dementia. Our other hotels are the Windsor and the Pacific Bay Inn. Two additional hotels, the Star and the Camelot, will be opened by July 2002 and will provide an additional 109 units of housing. All told, our housing unit now provides 1,120 housing placements: more housing than any other health department in the State of California, perhaps anywhere in the United States.

Due to the strong commitment of the Board of Supervisors and Mayor Brown, San Francisco has been committed to providing community-based treatment upon demand to active drug users since 1997. A recent independent evaluation of San Francisco's Treatment on Demand Initiative by the University of California, San Francisco, concluded that "the San Francisco Treatment on Demand initiative, which coupled a community planning process with annual increases in treatment funding, is a feasible and effective way of increasing access to publicly funded substance abuse treatment." The evaluation found that total admissions per year to the treatment system increased 15 percent (from 23,586 in FY 1995-96 to 27,103 in FY 1998-99) and the number of individual people accessing treatment increased 18 percent. After implementation of Treatment on Demand, people entering treatment for the first time and persons with heroin addiction each constituted greater proportions of all treatment admissions.

The Department's Community Mental Health Services (CMHS) made significant progress over the last year to reduce reliance on acute or emergency psychiatric care. CMHS

worked closely with San Francisco General Hospital's Department of Psychiatry to improve patient flow through the acute psychiatric units by placing patients in appropriate community programs, thereby reducing the rate of hospital admissions for patients receiving emergency psychiatric services. CMHS was also able to expand its outreach services to homeless persons with mental illness through the successful Mobile Outreach Support and Treatment (MOST) Team that operates out of the South of Market Clinic. As of March, there were 123 participants in the program and program data show that among program participants, hospitalization has decreased 58 percent, incarceration has decreased 81 percent, and 86 of the 123 participants are currently maintaining stable housing.

Like other public health systems around the country, the Department continues to see a high proportion of uninsured patients at San Francisco General Hospital and the Department's primary care clinics. Last year, 50 percent of our patients were uninsured. However, I am fortunate to be a local health director in a city that so strongly supports public health and health care services. San Francisco has been a leader in efforts to expand access to health care coverage for its uninsured residents and workers and I am proud that the Department has played a role in these expansions. In January of this year, in collaboration with the San Francisco Health Plan, the City launched Healthy Kids, the City's health insurance plan for children. I am pleased to report that as of March 2002 – just three months into the program – 483 children previously uninsured San Francisco children now have health insurance.

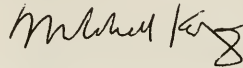
HIV/AIDS continues to have an enormous impact on the health of San Franciscans. The level of HIV/AIDS prevalence is higher now than ever, with one out of every fifty San Franciscans living with HIV/AIDS, due to the availability of highly effective antiretroviral treatments. Unfortunately, San Francisco is also experiencing a resurgence of new HIV

infections, particularly among men who have sex with men (MSM). Infection rates are going up again, along with growing epidemics of hepatitis C and sexually transmitted diseases. At the same time, essential Ryan White CARE Act funds to San Francisco are being reduced by an unprecedented \$2.2 million. The Department will continue to work closely with the Board of Supervisors and the HIV Planning Council to mitigate the impact of the reductions on critical HIV services.

We recognize that the economic recession has had a major impact on the City's revenue, and that this may affect the availability of general funds for the Health Department. With a proposed baseline budget of just over a billion dollars the Health Department is the largest department in the City. However, it is important to note that 69% of our funding is revenue generated. Therefore, most potential cuts of general fund become magnified: cutting general fund supported services results in the loss of revenue, resulting in further cuts of services. In the coming months the Board will be deliberating on this budget. We are prepared to follow the leadership of the Mayor and the Board and contribute as is necessary to help the City to close its budget deficit. At the same time, we are mindful that it is impossible to cut the safety net without endangering the safety net.

I would like to recognize the Department's staff and their continued commitment to providing services in a manner that promotes community-based alternatives and expanded access. Our ability to meet the health needs of our community is dependent upon the caliber of our staff. I am proud and appreciative of their expertise, their dedication, and their spirit. I would also like to acknowledge the San Francisco Health Commission for their vision and leadership on health issues.

Thank you for the opportunity to speak to you today regarding the public health of our City. I look forward to working with you over the next year to fulfill the Department's mission to protect and promote the health of San Franciscans.

A handwritten signature in black ink, appearing to read "Mitchell Katz", with a stylized flourish at the end.

Mitchell H. Katz, M.D.
Director of Health
April 2002

The Department's Strategic Plan

For the past year, the Department's direction has been guided by its Strategic Plan, which was adopted by the Health Commission in January of 2001 and designed to help the Department better fulfill its mission to protect and promote the health of all San Franciscans. The Department undertook this strategic planning initiative in an effort to ensure that the services and programs that the Department provides are continually relevant to the health needs and concerns of the community. As you will see from this report, the Department's responses to the City's health issues were developed in accordance with our Strategic Planning objectives.

San Francisco's Health Status Profile 2002

MAJOR CAUSES OF DEATH, SAN FRANCISCO 1999-2000

SF Rank	Health Status Indicator	Deaths (Avg./ Yr.)	SF Death Rate	95% Conf. Limits (Lower, Upper)	CA Death Rate	SF/CA	US 2010 Obj.	SF Met 2010 Obj.?
10	ALL CAUSES (1998-2000 AVERAGE)	6,587.3	698.4	667.9 728.9	773.8	90.3	N/E	----
22	CORONARY HEART DISEASE	1,544.0	159.2	151.2 167.2	201.5	79.0	166.0	Yes
26	CEREBROVASCULAR DISEASE	595.0	60.4	55.5 65.2	63.3	95.4	48.0	No
9	ALL CANCERS	1,515.5	165.0	156.7 173.4	179.8	91.8	159.9	No
6	LUNG CANCER	362.5	39.8	35.7 43.9	46.8	85.0	44.9	Yes
4	FEMALE BREAST CANCER	92.0	18.3	14.5 22.1	25.2	72.6	22.3	Yes
12	DIABETES	128.5	13.7	11.3 16.1	20.8	65.9	45.0	Yes
----	AIDS	198	21.7	----	4.5	4.88	----	----
27	UNINTENTIONAL INJURIES	281.5	32.7	28.8 36.6	24.7	132.4	17.5	No
12	MOTOR VEHICLE ACCIDENTS	54.5	6.8	4.9 8.6	9.8	69.4	9.2	Yes
24	SUICIDE	88.0	10.4	8.2 12.6	9.5	--	5.0	No
46	HOMOCIDE	50.5	6.8	4.9 8.8	6.1	--	3.0	No
56	DRUG-RELATED DEATHS	158.5	18.2	15.4 21.1	5.8	313.8	1.0	No
14	FIREARM INJURIES	48.5	6.5	4.6 8.4	9.3	69.9	4.1	No

Notes: Rank goes from lowest county rate (rank #1) to highest rate (#56).

Rates are age-adjusted to US 2000 population standard, and are calculated per 100,000 population.

Three-year averages are reflected for the "All Causes" mortality data.

Due to the change from ICD9 to ICD10 that occurred in 1999, two years of mortality data are used for specific causes.

Rates cannot be compared to data prior to 1999 due to the change from use of 1940 to 2000 standard population proportions to calculate age-adjustments.

SF/CA: SF rate/CA rate x 100. Can be read as SF's rate as a percent of California's. Not shown if CA rate included in SF's 95% C.I.

N/E: National Objective for all-cause mortality has not been established.

Source: Department of Health Services: Center for Health Statistics, County Health Profiles 2002. April 2002.

Data Sources: Department of Health Services: Center for Health Statistics, *Death Statistical Master Files*, 1998-2000. Department of Finance, *1999 Population Projections with Age, Sex and Race/Ethnic Detail*, May 2000.

Improving the Department's ability to respond in case of disaster

OBJECTIVE

All residents and visitors will continue to have access to and benefit from population-based public health services.

ISSUE

Since 9/11, the Department has been on heightened alert and has worked to increase its ability to react effectively in case of disaster.

RESPONSE

The Emergency Medical Services (EMS) section has focused on bioterrorism by engaging in the following activities:

- ◆ released a final version of the Multicasualty Incident Plan and trained all Fire Department employees;
- ◆ upgraded the City's cache of medical supplies;
- ◆ worked with the State to rapidly access federal supplies through the "National Pharmaceutical Stockpile" if needed;
- ◆ improved the Department's Operating Center in case of a disaster; and
- ◆ worked with community hospitals (e.g., St. Luke's, St. Francis, Chinese Hospital, etc.) to improve their disaster plans.

The Community Health Epidemiology and Disease Control section has focused on the following activities:

- ◆ planning and testing a Prevention Treatment Center for mass post-exposure drug prophylaxis;
- ◆ planning and testing a rapidly deployable epidemiologic and environmental Field Investigation Team;
- ◆ continuing education for clinical providers on the recognition and management of bioterrorism agents; and
- ◆ developing and testing a clinical provider Health Alert Network for rapid notification and information dissemination.

Improving the Department's ability to respond in case of disaster

OBJECTIVE

Health care services will continue to be provided to the target and vulnerable populations, in addition to those who choose the Department.

ISSUE

Following published and televised anthrax cases and exposures on the east coast in early October 2001, the Department's Emergency Response Team responded to over 170 calls of suspected anthrax in San Francisco. Calls came from concerned individuals who received suspicious or unusual letters or packages often containing white powder or labeled with threats.

RESPONSE

The Emergency Response Team includes four employees who are on call around the clock and respond, along with the Fire Department, to all Hazardous Materials calls. These staff members collected all suspicious letters and delivered them for assessment. 140 samples were evaluated by the Department's Microbiology Lab for assessment, and the California Department of Health Services evaluated other samples associated with more significant threats. None of these samples were ultimately found to contain anthrax.

Decreasing homelessness and increasing affordable housing

OBJECTIVE

Health care services will continue to be provided to the target and vulnerable populations, in addition to those who choose the Department.

ISSUE

Over 450 families and 760 children are living in San Francisco's Single Room Occupancy hotels (SROs). Half of the parents with families in SROs reported that living there had caused health problems for them and their children.¹

RESPONSE

The Office of Housing and Urban Health conducted a health fair at two residential hotels. Staff provided flu shots, HIV testing and counseling, STD screening and treatment, tuberculosis screening and urgent care medical services to over 50 residents.

In 2001, the Hotel Inspection Program Unit prioritized its inspections to ensure that SRO hotels and other facilities are safe, sanitary and habitable. In the Fall of 2001, planning began for inspections on each of the 106 SRO hotels that house families. These inspections are set to begin in May 2002.

OBJECTIVE

Advocate for non-health public policies that improve health status such as wages, employment, childcare, housing, social safety net, transportation and education policies.

ISSUE

Community groups who work with families in SROs hear repeated complaints: filth, rodent infestations, drug abuse and dealing in their SROs, abusive and unresponsive managers, and poorly lit, non-ventilated and cramped rooms.²

RESPONSE

The Department has provided additional funds to the three SRO Collaboratives (the Mission, Chinatown and Central City SRO Collaboratives). These funds allow the SRO Collaboratives conduct educational seminars and advocacy training for tenants and landlords. Topics to be covered include improving conditions, tenants rights, and accessing health care.

¹ Citywide Families in SROs Collaborative, *Report on the Census of Families with Children Living in Single Room Occupancy Hotels in San Francisco*, October 2001.

² Ibid.

Decreasing homelessness and increasing affordable housing

OBJECTIVE

Develop policies to support and institutionalize service integration through a client-centered focus rather than a service or funding focus, when appropriate.

ISSUE

San Francisco does not have enough housing for homeless and disabled individuals needing comprehensive long-term care or supportive housing.

RESPONSE

The Department opened Broderick House, a 24-bed residential care facility, to provide long-term care for clients who have been difficult to place due to medical complications and/or behavioral problems. By June 30, 2002, the Department will have added 109 units of permanent supportive housing at the Star and Camelot hotels.

OBJECTIVE

Advocate for non-health public policies that improve health status such as wages, employment, childcare, housing, social safety net, transportation and education policies.

ISSUE

Homelessness creates or exacerbates health problems, mental health problems and addiction. Many of San Francisco's homeless residents suffer from a combination of these problems.

RESPONSE

The Community Mental Health System initiated a project aimed at linking homeless seriously mentally ill clients with mental health treatment, housing, and employment development. With 120 homeless clients enrolled, over 70 percent of them are maintaining housing and eight enrollees are employed. Both hospital and incarceration days have decreased significantly for enrollees.

Enhancing long-term care services

OBJECTIVE

Expand community-based services (including social, restorative and rehabilitative models). Community-based alternatives (which are provided in community and institutional settings) should be expanded in place of institutional care whenever clinically appropriate.

ISSUE

The population today at Laguna Honda Hospital and Rehabilitation Center (LHHRC) is younger and the range of diagnoses and disabilities more varied. As of June 30, 2001 there were 198 patients under 55 years old residing at LHHRC, three times the number of patients under 55 residing at the facility 10 years ago.

RESPONSE

Medical advances and the availability of community programs now make it possible to discharge residents more quickly, with short-term care as the goal. The Community Reintegration Program targets individuals who demonstrate the potential for discharge within 90 days of admission. In 2001, the program's first year, 87 individuals were admitted to the program, 53 of whom were successfully discharged.

OBJECTIVE

Train staff to develop and deliver appropriately integrated services.

ISSUE

A variety of ethnic groups make up the residents at LHHRC, 25 percent of the residents are African-American, over 20 percent are Asian Pacific Islander, and 10 percent are Hispanic/Latino. Many of the residents are monolingual Chinese or Spanish.

RESPONSE

LHHRC established Asian Focus Units where staff is placed and residents voluntarily reside in units to meet the specific linguistic, cultural and nutritional needs of Chinese speaking residents. The interdisciplinary team members for these units include bilingual and bicultural staff from nursing, dietary, medicine, rehabilitation, activity, social services, and volunteers.

Enhancing long-term care services

OBJECTIVE

Health care services will continue to be provided to the target and vulnerable populations, in addition to those who choose the Department.

ISSUE

Currently, individuals aged 65 and over constitute 15 percent of the City's population. It is estimated that 23 percent of these individuals have mobility and self-care limitations requiring long-term care (either in the community or in an institution). The City's population of older people is expected to increase as the baby boomer generation ages.

RESPONSE

The LHHRC Replacement Project has been moving forward since Proposition A passed in November 1999, making it mandatory to replace LHHRC to serve more of the City's residents in a newer, higher quality setting. Highlights in this area over the past year include:

- ◆ Completed the schematic design;
- ◆ Produced preliminary construction phasing plan;
- ◆ Published draft environmental impact report;
- ◆ Submitted completed plans for temporary power plant to the Office of Statewide Health Planning and Development for approval; and
- ◆ Submitted final plans for new expanded Woodside Roadway for issuance of construction permits.

OBJECTIVE

Identify priority health issues that can be addressed through prevention activities undertaken across the Department.

ISSUE

As a population, LHHRC residents are younger, more likely to be male, come from lower-income backgrounds, have more substance abuse and psychosocial problems, and have higher levels of impaired mobility. Approximately 400 residents of LHHRC have psychiatric diagnoses in addition to their medical problems.

RESPONSE

An increasing portion of the younger male population requires programs that minimize aggression. Training for staff in managing difficult behavioral problems was instituted. In addition, the Young Independent Persons Society (YIPS) was developed to meet the activity and interest needs of this group. Evening activities geared toward younger residents, like pizza parties and live music, occur every two weeks and are regularly attended by 20 to 25 residents.

Providing treatment to those with substance abuse and addiction problems

OBJECTIVE

Health care services will be provided to the target and vulnerable populations, in addition to those who choose the Department.

ISSUE

The high cost of rent and the lack of appropriate space in San Francisco creates barriers to expanding critically needed methadone maintenance treatment slots. San Francisco has about 1,675 methadone maintenance slots, but the need is much greater.

RESPONSE

The Mobile Methadone Project will add 150 methadone maintenance slots for indigent individuals in San Francisco in Spring of 2002. The vans will provide methadone dispensing and counseling services. Mobile methadone services will be available Monday through Friday to clients and on the weekends at San Francisco General Hospital. This program will work in conjunction with existing programs (Ward 93 at San Francisco General Hospital), and will be staffed by a Dispensing Nurse, a certified counselor and a security guard. As substance abuse counseling is an integral and required part of methadone maintenance treatment, counselors will be located in the facility where the vehicle is parked. Crisis counseling will be available by a trained counselor on the vehicle.

The Office-Based Opiate Addiction Treatment (OBOAT) program will be piloted in the Spring of 2002, and will allow clients to access methadone treatment from physicians in the City. Methadone will be dispensed to the client from participating neighborhood pharmacies, allowing 100 individuals to access treatment closer to home.

Providing treatment to those with substance abuse and addiction problems

OBJECTIVE

Ensure that priority services are those which address the critical health issues and socio-economic needs of the target populations, vulnerable populations and neighborhood areas.

ISSUE

San Francisco has an estimated 15,000 to 17,000 heroin addicts. San Francisco had a rate of 20.1 drug related deaths per 100,000 people in 2000. This is significantly higher than the State's average rate of 5.8; the National Objective for 2010 is 1.0 per 100,000.³

RESPONSE

Spaces available for direct treatment of substance abuse/addiction (including methadone maintenance, detoxification programs, residential treatment programs, etc.) increased by 23 percent since FY 1999-2000 and 53 percent since the Treatment on Demand Initiative was initiated in 1996. In FY 2000-2001 there were a total of 6,334 slots contracted for by the Department.

OBJECTIVE

Foster collaborative planning on health issues and assessment with consumers, community partners, researchers, other City agencies, neighborhood organizations and others to improve health status.

ISSUE

Many individuals in San Francisco are dependent on a combination of alcohol, sedatives and opiates, which tend to produce the greatest degree of physical dependence.

RESPONSE

The Ozanam Medically Managed Detoxification Program opened in the Summer of 2001, bringing vital medical services and expertise to a community-based setting. The program took 20 existing detoxification beds at Ozanam and enhanced them with 24-hour medical monitoring, and is a collaboration between the Department, St. Vincent de Paul, and UCSF.

³ California Department of Health Services, *County Health Status Profiles*, April, 2002.

Providing treatment to those with substance abuse and addiction problems

OBJECTIVE

Initiate and sustain partnerships with non-profit, private, governmental, community and faith-based agencies to provide health-related services and advocate for solutions to root causes of poor health such as poverty, underemployment, and inadequate housing.

ISSUE

The Department's Community Substance Abuse Services (CSAS) has a broad and culturally diverse clientele. African-Americans represent 32 percent of CSAS patients – four times the percentage of African-American residents in San Francisco; Hispanic/Latino clients also are represented in higher proportions than reside in the City; Asian/Pacific Islanders and "Other" ethnicities make up approximately 10 percent of the clientele.

RESPONSE

The San Francisco Practice Improvement Collaborative (PIC) strives to improve the quality of substance abuse treatment by increasing interaction and knowledge exchange between community-based providers and the research community. Last year, the PIC conducted trainings to providers on cultural competency for African-Americans, Native Americans, Hispanic/Latino, lesbian/gays, and transgenders.

Improving services for those with mental health problems

OBJECTIVE

Expand community-based services (including social, restorative and rehabilitative models). Community-based alternatives (which are provided in community and institutional settings) should be expanded in place of institutional care whenever clinically appropriate.

ISSUE

Inpatient psychiatric care represents the most restrictive and expensive level of care in the mental health system. Community Mental Health Services (CMHS) strives to serve clients in the least restrictive environment.

RESPONSE

In FY 2000-2001 there were 160 fewer psychiatric hospitalizations than the previous year. This decrease is due in part to the continued work of the intensive case management programs, including the Single Point of Responsibility programs (SPRs). The SPRs are innovative programs designed to provide wraparound services 7 days per week in order to assertively engage clients and encourage their ability to live productive lives in the community rather than within institutions.

This decrease in hospitalizations is also the result of the availability of supportive housing, acute diversion residential programs, and the Mobile Crisis Team that works closely with the police. All of these programs contribute to the CMHS goal of treating clients in the community and reducing the need for psychiatric emergency services and inpatient hospitalization.

OBJECTIVE

Health care services will be provided to the target and vulnerable populations, in addition to those who choose the Department.

ISSUE

There are approximately 12,515 children and youth between 0 and 17 years old considered seriously emotionally disturbed in San Francisco. Many are in treatment through CMHS, but some remain undiagnosed and/or untreated.⁴

RESPONSE

CMHS, the San Francisco Unified School District and Westside Community Mental Health Services opened a school-based day treatment program at the Visitacion Valley middle school. This program will pilot a new model of delivering mental health services to seriously emotionally disturbed children at the school site.

⁴ California Mental Health Planning Council, *California Mental Health Master Plan, Draft*, August 2001.

Improving services for those with mental health problems

OBJECTIVE

Ensure that a single standard of care, that meets community standards, is provided to clients regardless of eligibility, income or residency status.

ISSUE

Mental health treatment must take place in the context of the consumer's culture. African-Americans make up 23 percent of the CMHS client base, nearly three times the percentage of African-Americans in San Francisco's general population. Asian/Pacific Islander patients make up 18 percent of the client base, while Hispanic/Latino clients make up 13 percent.

RESPONSE

Several projects were launched to improve the cultural competency of CMHS. Examples include the Asian Leadership Consumer Group, which recently held a workshop on becoming a U.S. citizen, and the Peer Internship program that pays consumers a stipend as they work in mental health programs and learn to become peer support counselors.

OBJECTIVE

Aggressively pursue grant and other funding sources outside of the Department and City including establishment of a grant writing function in the Department.

ISSUE

It is estimated that nearly 5,000 adults over 60 years old in San Francisco need mental health services, and nearly half of these individuals have mental health needs that remain unmet through CMHS and the private sector.⁵ These older adults and their families have difficulty navigating between the physical and mental health systems of care.

RESPONSE

The Older Adult System of Care grant from the State Department of Mental Health provides an opportunity to demonstrate how San Francisco's physical and mental health systems can collaborate by creating an integrated 24-hour crisis response system. A residential care facility is designated as the setting to assess, diagnose and intervene when it is not possible to provide services in the client's home.

⁵ California Mental Health Planning Council, *California Mental Health Master Plan, Draft*, August 2001.

Improving services for those with mental health problems

OBJECTIVE

Work more closely and collaboratively with other City agencies that provide human services to ensure that program efforts are coordinated and responsive to the larger goal of improving the quality of life for San Francisco residents.

ISSUE

The San Francisco Police Department (SFPD) responds to about 600-700 calls per month dealing with individuals suffering from mental illnesses. The SFPD and CMHS need to work together to make sure that individuals with mental health issues receive appropriate services as quickly as possible.

RESPONSE

SFPD and CMHS developed and implemented a Police Crisis Intervention Training Program, which trains officers to be better able to respond to individuals with apparent mental illness and to be informed of the mental health resources in the City. Two training classes were held in May and October 2001. Fifty-five officers have been trained and the officers positively evaluated the training. More classes are being planned for 2002.

Increasing access to health insurance for the City's residents

OBJECTIVE

Foster collaborative planning on health issues and assessment with consumers, community partners, researchers, other City agencies, neighborhood organizations and others to improve health status.

ISSUE

More than one in three workers who lose their job also lose their health insurance.⁶ San Francisco's unemployment rate was 4.9 percent (49,559 residents) in November 2001, more than doubling from the previous year.⁷ The economic downturn in the Fall of 2001 likely added nearly 11,000 adults to the ranks of San Francisco's uninsured.

RESPONSE

In November 2001, the Department and the Mayor's Office created "Health Insurance Options for Laid-Off Workers," a document instructing individuals how to retain or find new health coverage. Translated into Spanish and Chinese, the document was widely distributed to job centers, Medi-Cal offices, and community-based organizations.

OBJECTIVE

Increase the number of insured San Franciscans through ensuring that those who are eligible, but not enrolled in publicly-funded or private programs are enrolled, developing a local health insurance purchasing program and advocating for expansion of public insurance programs.

ISSUE

Previous estimates show that over 9,000 children in San Francisco are uninsured. Approximately 5,000 of these children are not eligible for Medi-Cal or Healthy Families.

RESPONSE

The Healthy Kids program provides health coverage for uninsured children and youth not eligible for other public health coverage programs. Healthy Kids covers undocumented immigrant children and children in working families with incomes too high for Healthy Families, but too low to afford private insurance. This program began in February 2002, and provides medical, prescription, vision and dental care.

⁶ Jeanne Lambrew, *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance*, Nov. 2001.

⁷ U.S. Dept. of Labor, Bureau of Labor Statistics website, February 2002.

Increasing access to health insurance for the City's residents

OBJECTIVE

Increase eligibility outreach efforts of the Department and coordinate eligibility efforts with other City departments (e.g., Department of Human Services and the San Francisco Unified School District). Work with other City Departments to identify mutual clients who can increase revenue or benefit from inter-agency case management.

ISSUE

The San Francisco rolls for Medi-Cal for Children increased from 18,328 in January 2001 to 19,001 in January 2002 (an increase of 673 children). The Healthy Families program increased from 8,314 in January 2001 to 9,545 in January 2002 (an increase of 1,231). However, there still remains a significant number of children who are uninsured, particularly given the increase in the number of unemployed parents.

RESPONSE

The Bringing Up Healthy Kids (BUHK) coalition is a partnership of City agencies and community-based organizations committed to increasing the number of insured children and improving access to health care for San Francisco's children. In September 2001, BUHK worked with the school district to send Requests for Information to all students. To date, approximately 1,300 forms have been sent back by parents interested in learning more about free or low-cost health coverage options. These families are being screened and assisted through the enrollment process.

Providing effective HIV/AIDS treatment and prevention services

OBJECTIVE

Health care services will continue to be provided to the target and vulnerable populations, in addition to those who choose the Department.

ISSUE

For African-American men the incidence of AIDS cases per 100,000 residents in San Francisco is 202, for white men it is 177. For women, the difference is even greater. African-American women have an incidence of 61 AIDS cases per 100,000 residents, three times higher than the incidence in the Hispanic/Latino female population and six times the incidence for white women.

RESPONSE

In 2001, five new and expanded programs were designed to bring people of color into care. These programs provide outreach and treatment advocacy for several underserved communities, including transgender, women of color, Asians and Pacific Islanders, monolingual Latinos, and Native Americans. The programs use culturally appropriate methods and provide treatment readiness for counseling, adherence support, and education.

The HIV Early Intervention Program (EIP) provides confidential, culturally sensitive medical evaluation and treatment, health education and social services for HIV infected individuals and family members. The EIP also seeks to prolong the health and productivity of the population and to decrease the transmission of HIV and the incidence of new cases among the BVHP community residents.

OBJECTIVE

Develop policies to support and institutionalize service integration through a client-centered focus rather than a service or funding focus, when appropriate.

ISSUE

Although there are fewer new cases of intravenous drug users (IDUs) reported as HIV positive, there are a total of 1,385 IDUs who are HIV positive and 2,080 IDUs who are men who have sex with men. This represents 75 percent of all HIV cases in the City.

RESPONSE

The Department now provides medical care at all 14 Needle Exchange sites. The sites are used to educate injection users to treat urgent medical conditions, teach HIV prevention, and to refer to ongoing primary care and drug treatment.

Providing effective HIV/AIDS treatment and prevention services

OBJECTIVE

Use evaluation data as part of establishing Department priorities. This process should be ongoing and updated annually to measure programs to ensure that they are still useful and meeting the Department's priorities.

ISSUE

The number of HIV positive transgender individuals in San Francisco is increasing. HIV prevalence among male-to-female transgender persons in San Francisco is 35 percent.

RESPONSE

The Transgender Community Health Project was conducted in San Francisco and was the first major study of the transgender population. The project greatly improved knowledge of the transgender community, HIV risk and prevalence, and need for targeted primary and secondary HIV prevention services. The community report and subsequent publications have been widely cited and used to secure funding for transgender services.

OBJECTIVE

Ensure that a single standard of care, that meets community standards, is provided to clients regardless of eligibility, income or residency status.

ISSUE

The prevalence of HIV infection among prisoners in the jail is much higher than in the general population. The incidence of HIV/AIDS is 14 times higher in state and federal correctional systems than in the general US population.⁸

RESPONSE

Jail Health Services uses the period of incarceration as an opportunity to provide HIV education, risk assessment and healthcare. The Homebase Project/HOPE Study was implemented to assess the effectiveness of interventions to enhance post-release medical and social service utilization, increase medication adherence, reduce health risk behaviors and reduce recidivism.

⁸ American College of Physicians, National Committee on Correctional Health Care, American Corrections Health Services Associations. *The crisis in correctional health care: the impact of the national drug control strategy on correctional health services*, Ann Internal Medicine, 1992: 117:17-7.

Providing effective HIV/AIDS treatment and prevention services

OBJECTIVE

All residents and visitors will continue to have access to and benefit from population-based public health services.

ISSUE

In San Francisco, 17,838 individuals are infected with HIV and as many as 3,500 do not yet know it. It is estimated that the number of new HIV cases in San Francisco has risen from about 500 in 1997 to a little over 1,000 in 2001.

RESPONSE

For National HIV Testing Day on June 27, the Department publicly encouraged all San Franciscans to get tested, and for those at risk to get tested every six months. Lists of anonymous and confidential HIV testing sites around the City were given out through a telephone hotline and Internet site.

OBJECTIVE

Engage in strong advocacy at the local, state and federal levels.

ISSUE

Though AIDS has been a reportable condition in California for several years; HIV became reportable just last year. The Department took a strong position opposing the use of names for reporting HIV cases to avoid deterring people from testing.

RESPONSE

The AIDS Office conducted a pilot study that demonstrated complete and accurate data could be collected without the use of names. The Department advocated strongly with the State Legislature and the Department of Health Services to ensure that the method of HIV reporting would be non-names based. The State now proposes to use unique identifiers, not names.

Preventing untimely disease, injury and death

OBJECTIVE

Identify priority health issues that can be addressed through prevention activities undertaken across the Department.

ISSUE

The adult smoking prevalence rate in San Francisco is nearly 18.7 percent, slightly higher than the overall rate in California of 18.2 percent. The Healthy People 2010 objective is 15 percent.

RESPONSE

The Tobacco Free Project's comprehensive tobacco control model has contributed to a 2.2 percent decline in the adult smoking prevalence rate in San Francisco in the last decade. In 2001, smoking cessation classes at San Francisco General Hospital had a 57 percent success rate and classes held for lesbian, gay, bi-sexual or transgender smokers had a 70 percent success rate.

OBJECTIVE

Ensure that prevention is a core component of new program initiatives and is part of the overall design of any new service.

ISSUE

The majority of car seats are being used in cars incorrectly. It was discovered that in San Francisco more than 95 percent of car seats are not being used optimally and some of these misuses could lead to a fatal injury.

RESPONSE

The Department sponsored a series of free car seat inspections in 2001. Trained inspectors checked for loose harnesses, safety seats not attached firmly to the car, infants facing the front of the car or riding in front with an air bag, and children being moved out of car seats before they are tall enough to fit properly in vehicle belts. In these cases, parents were given information and training on the appropriate use of safety seats and the dangers of improper use.

Preventing untimely disease, injury and death

OBJECTIVE

All residents and visitors will continue to have access to and benefit from population-based public health services.

ISSUE

Over the past 10 years, San Francisco pedestrian fatalities have become a steadily increasing percentage of fatal motor vehicle collisions, from about 37 percent in 1990 to over 60 percent in the year 2000. This is in comparison to a national figure of about 13 percent of motor vehicle pedestrians.

RESPONSE

During National Red Light Running Week in September 2001, the Red Light Running Prevention Campaign distributed "RED means STOP" buttons and antennae balls to drivers. The City's over 2,000 Emergency Crews and First Responders (including Emergency Medical Technicians, Paramedics, Firefighters and Police) also wore the buttons and placed the antennae balls on their vehicles to remind people of the dangers of red light running. Billboards, and street signs were displayed with the message "Stop at the red. You'll only kill a few seconds."

OBJECTIVE

Ensure that prevention is a core component of new program initiatives and is part of the overall design of any new service.

ISSUE

San Francisco's senior pedestrians are being killed at three times their proportion of the population and once they are injured in a collision, seniors are four times more likely to die.

RESPONSE

The Department hosted a rally in May 2001 on the steps of City Hall in recognition of Senior Pedestrian Awareness Day. The event kicked off a new senior pedestrian safety poster campaign that featured photos of seniors and contained the following types of messages: "He Wants to be a Grandfather, Not Another Pedestrian Fatality" or "She Wants to Visit her Grandson, Not the Emergency Room."

Preventing untimely disease, injury and death

OBJECTIVE

Foster collaborative planning on health issues and assessment with consumers, community partners, researchers, other City agencies, neighborhood organizations and others to improve health status.

ISSUE

Nearly 50 percent of San Francisco's middle school students reported that they had been in a physical fight in the last year, and 15 percent said that they had not attended school at some time because they had felt unsafe.⁹

RESPONSE

The Transitions program targets fifth grade students in the schools, preparing them for challenges they may face in middle school and adolescence. Violence prevention, including the issues that surround teasing and bullying, are explored in depth. In the 2000-2001 school year, almost 1,500 children at 25 schools benefited from this program.

⁹ San Francisco Unified School District, *Middle School Health Survey – Executive Summary*, September 2000.

Addressing health disparities among different communities

OBJECTIVE

Ensure that priority services are those which address the critical health issues and socio-economic needs of the target population.

ISSUE

When Asians immigrate to the United States, risk of developing diabetes increases significantly. This is likely due to a change in lifestyle, diet, and exercise. Nationally, an estimated 2.4 percent of Asian American/Pacific Islander (AAPI) women have diabetes, the fifth leading cause of death among AAPI women between the ages of 45 and 64.¹⁰

RESPONSE

The Chinatown Public Health Center has developed and implemented a diabetes education and case management program. This effort maximizes resources and provides access to critical diabetes management services using the adaptation of language and culture. Over 200 Chinese clients have participated in case management, self-management classes, culturally sensitive nutrition services and a support group.

OBJECTIVE

2.3(a) Advocate for non-health public policies that improve health status such as wages, employment, childcare, housing, social safety net, transportation and education policies.

ISSUE

Large inequalities exist in the health of the U.S. population, as well as in San Francisco. Recent lessons from health, social, and behavioral research have demonstrated the importance to health and well being of a wide range of social, economic, cultural, and institutional factors as well as the limits of medical approaches to address inequalities.¹¹

RESPONSE

The Health Inequities Research Unit (HIRU) was created by the Department in 2001 to address health issues that are important for the health of low-income individuals, families and neighborhoods. All of the projects undertaken by the HIRU support and evaluate change in environmental conditions. Nutritious and accessible food, safe and affordable housing, opportunities for physical activities, and safe/well-paid jobs are some of the specific areas of focus.

¹⁰ Fuhimoto, *Diabetes in Asian and Pacific Islander Americans*, 1995.

¹¹ Michael Marmot, *Social Determinants of Health*, Oxford, 1999.

Addressing health disparities among different communities

OBJECTIVE

Foster collaborative planning on health issues and assessment with consumers, community partners, researchers, other City agencies, neighborhood organizations and others to improve health status.

ISSUE

According to the Bayview Hunter's Point Health and Environmental Assessment Task Force, one in six children, or 15.5 percent, were asthmatic. This is more than twice the national average for 5 to 14 year olds, which is 7.4 percent. African-Americans in San Francisco are reported to have two to three times the rate of asthma as whites.

RESPONSE

The YES WE CAN Urban Asthma Partnership comprises 11 organizations that advocate for low-income communities on issues of child health and community wellness. The Urban Asthma partnership implemented a medical/social model at the Pediatric Asthma Clinic at SFGH. Last year, the clinic served nearly 700 asthmatic children living in the southeast areas of the City.

OBJECTIVE

3.7(d) Incorporate e-health into the Department's Internet strategy and fund a comprehensive Department portal for a more dynamic presence on the Internet.

ISSUE

The rate of premature death among African-Americans in San Francisco is more than one and one-half times that of all San Franciscans, with the leading causes being heart disease, AIDS, drug overdose, stroke and homicide. To a large extent, each of these causes of premature death is preventable.

RESPONSE

The African-American Telehealth Project is demonstrating a new approach to addressing these health disparities. It combines community-organizing trainings with a new tool, locally created and maintained Web sites. These sites will be used by their respective communities and will facilitate partnerships resulting in the creation of "e-clubs." These groups will gather weekly for several months to be trained in organizing for health and to learn Web authoring.

Addressing health disparities among different communities

OBJECTIVE

Initiate and sustain partnerships with non-profit, private, governmental, community and faith-based agencies to provide health-related services and advocate for solutions to root cause of poor health such as poverty, underemployment, and inadequate housing.

ISSUE

Women in San Francisco receive early and adequate prenatal care 74 percent of the time as compared to the Healthy People 2000 objective of 80 percent and the Healthy People 2010 objective of 90 percent. However, African-American women in San Francisco receive early and adequate prenatal care only 57 percent of the time. African-American women who do not receive early and adequate prenatal care are more likely to have negative birth outcomes and are nearly twice as likely to have low birth weight infants.

RESPONSE

To increase the number of pregnant women accessing prenatal care, the Department stationed a public health nurse (PHN) at the Medi-Cal site to refer pregnant clients for prenatal care case management. Depending on their residence, women may be referred to the Black Infant Health Program, or the Sistah Sistah program. Homeless women are referred to the Homeless Prenatal Program. These programs, among others, are succeeding in getting women into care and reducing the number of low birth weight African-American infants.

Controlling the spread of communicable diseases

OBJECTIVE

Ensure that priority services are those which address the critical health issues and socio-economic needs of the target populations, vulnerable populations and neighborhood areas.

ISSUE

According to preliminary reports, early syphilis cases rose from 44 cases in 1999 to 71 cases in 2000 (61 percent increase) and 190 cases in 2001 (168 percent increase). In San Francisco, cases among men who have sex with men accounted for 72 percent of all syphilis cases. If bisexual men are included, the percentage increases to 80 percent.

RESPONSE

Due to success in treating other STDs through Field Delivered Therapy (FDT), FDT is now available to treat syphilis. This allows Department staff to provide testing and therapy to hard-to-motivate syphilis contacts in the field rather than requiring them to come to the Clinic for treatment.

OBJECTIVE

Foster collaborative planning on health issues and assessment with consumers, community partners, researchers, other City agencies, neighborhood organizations and others to improve health status.

ISSUE

High-risk venues for the spread of STDs include adult bookstores, sex clubs, bathhouses and the Internet. All have been found to play a role in facilitating syphilis transmission.

RESPONSE

The STD program conducted outreach to MSMs at clubs. To reduce the spread of syphilis and other STDs the Department met with owners and managers of adult bookstores, and encouraged them to improve signage, make condoms more available in their arcades and to make information regarding testing and treatment available to patrons. The owners of all five of the City's sex clubs signed a STD Pledge agreeing to do their best to assure a safer sex environment at their establishment.

Controlling the spread of communicable diseases

OBJECTIVE

Health care services will continue to be provided to the target and vulnerable populations, in addition to those who choose the Department.

ISSUE

Tuberculosis (TB) rates have remained at an all time low in San Francisco in 2000 and 2001. However, there were 182 new cases of tuberculosis reported in San Francisco in 2001, a 7.1 percent increase from the number of cases in 2000. San Francisco's TB rate is four times the national average.

RESPONSE

Case finding through contact investigation, screening of immigrants, the incarcerated, and clients at methadone maintenance clinics has been highly successful. Treatment completion rates are 97 percent for those who remain in San Francisco for treatment, primarily attributable to the use of selective directly observed therapy (DOT). DOT targets individuals who are most infectious and least likely to adhere to treatment. The DOT program facilitates the patient's adherence to their treatment regimen by providing the medication in the clinic setting or by delivering it to their home, shelter or "hangout."

Responding to environmental health concerns

OBJECTIVE

Foster collaborative planning on health issues and assessment with consumers, community partners, researchers, other City agencies, neighborhood organizations and others to improve health status.

ISSUE

Each day in San Francisco, hundreds of day laborers are hired to perform high-risk tasks yet are rarely provided the required protections. Interventions are needed to reduce occupational injury and illness, decrease hazardous exposure to the general public, and to empower day laborers to address their own health and social needs.

RESPONSE

The Department, in collaboration with several community-based organizations, offers a health and safety program for day laborers, the Working Immigrants for Safety and Health. This collaboration provides training and resources, and extends outreach activities to businesses and individuals that employ day laborers.

OBJECTIVE

The following neighborhoods are considered priority service areas: Bayview Hunters Point, Chinatown, Mission, Outer Mission, Potrero Hill, South of Market, Tenderloin, Visitacion Valley.

ISSUE

Families lacking in food security do not always have access to enough food for active, healthy lives for all individuals. In San Francisco's Bayview Hunter's Point, barriers to food security include low income, transportation, lack of conveniently located quality food facilities and farmers markets, and neighborhood crime.

RESPONSE

The San Francisco Food Systems Council was created to ensure that all residents have access to nutritious and safe food. The Council is an integral part of food systems policymaking, ensures that San Francisco plays a leading role in supporting sustainable regional agriculture and advocates for policies which support existing governmental food security programs.



